Women's Health Check eManual

ABOUT THE . . .
WOMEN'S HEALTH CHECK EMANUAL

PURPOSE

This manual is a working guide for the day-to-day administration of providing breast and cervical cancer screening and diagnosis to older, uninsured women with limited family income and no other resources for these services.

The purpose of this manual is to describe the policies and procedures for contractors and providers of the Women's Health Check Program, a breast and cervical cancer screening program administered through the Bureau of Clinical and Preventive Services, Division of Health, Department of Health and Welfare and funded by Centers for Disease Control and Prevention through a cooperative agreement. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a landmark program that brings critical breast and cervical cancer screening services to medically underserved women. Early detection can reduce breast and cervical cancer mortality.

Questions related to the Women's Health Check Program should be directed to State *WHC* staff or Local Coordinating Contractors (LCC).

AUDIENCE

The primary audience for the Women's Health Check Manual consists of health care professionals located throughout the state that are involved in the process of delivering services to clients eligible for breast and cervical cancer screening and diagnosis through Women's Health Check.

CONTENT OVERVIEW

This manual offers providers a concise resource for managing *Women's Health Check* clients. Service summaries, forms, instructions, protocols and case management requirements are all included. We hope that this manual will aid you in understanding the important part you play by providing *Women's Health Check* services.

Eligibility
And
Enrollment

2006 *Women's Health Check* Eligibility Guidelines

- **Women aged 50-64** for Pap test, clinical breast exam and mammogram **or**
- **Women aged 40-49** for Pap test.
  Note: Women who have not had a Pap test or not had a Pap test in the last 5 years are at high risk for cervical cancer and are a priority for enrollment.
- Low Income (see table below)
- No health insurance coverage for Pap tests or mammograms
- Women over age 65 who are NOT eligible for Medicare or cannot afford Medicare Part B

- ***Limited enrollment and services*** *available for uninsured women who meet these additional criteria:*
  - *Age 30 – 49 and have symptoms suspicious of breast cancer confirmed by a health care professional*
  - *Age 30 – 39 and have symptoms suspicious of cervical cancer confirmed by a health care professional*

< 200% of Federal Poverty Level

Persons in Family Unit	Annual	Monthly
1	$19,600	$1,633
2	$26,400	$2,200
3	$33,200	$2,767
4	$40,000	$3,333
5	$46,800	$3,900
6	$53,600	$4,467
7	$60,400	$5,033
8	$67,200	$5,600
For each additional person, add	$6,800	$567

SOURCE: Federal Register, Vol. 71, No. 15, January 24, 2006, pp.3848-3849

Women's Health Check is a breast and cervical cancer screening program.
Women's Health Check provides Mammogram, Clinical Breast Exam, and/or Pap test for women who have no other resources for annual screening.

www.healthandwelfare.idaho.gov
Click on Women's Health Check

IDAHO DEPARTMENT OF HEALTH & WELFARE

WOMEN'S HEALTH CHECK CLIENT ENROLLMENT

Women shall be determined eligible for *Women's Health Check* (*WHC*) prior to receiving screening or diagnostic services.

ENROLLMENT

Every enrollment site shall be provided with *WHC* Client "Welcome" and annual "Welcome Back" packets.

- Staff at enrollment site shall maintain communication with LCC as to availability of resources or current waiting lists.

- Staff at enrollment site shall interview potentially eligible women to determine if they qualify for *WHC*, and would choose to enroll.

    - Staff checks eligibility and initials enrollment form to verify eligibility.
    - Client completes and signs Enrollment form.
    - Staff and client review Intake Assessment form, client initials and keeps copy.

- Staff shall instruct client to carry her *WHC* Enrollment card to all WHC related appointments, and present at front desk to photocopy for billing.

- Every year, client must complete and sign enrollment form in Welcome or Welcome Back packet, verifying her eligibility.

ELIGIBILITY QUESTIONS

1. **Income:**

    - What is your total household income before taxes? (Includes wages, unemployment or disability benefits, child support, tips, wages, personal income from any business activity)
    - How many people live in the household or are supported by the income listed above?

    Use responses from questions above to determine income eligibility by comparing information to *WHC* Eligibility Guidelines.

2. **Insurance:**

    - Do you have any health insurance? (Purchased individually, through employer, through any group plan, Medicaid, Medicare) If yes and younger than priority ages, do not enroll.

    For Priority Screening Population (see below):

    - If you have insurance or health care plan, does it cover preventative health services such as annual exams, mammograms, Pap tests?
        - If the client indicates that the deductible on her health insurance prevents her from obtaining a mammogram or Pap test, local staff may enroll client due to an insurance barrier, as long as she is in priority age group for screening.
        - Younger women referred for diagnostic tests are not eligible if they have any other health care insurance or resource for payment.

3. **Priority Screening Populations (75% of those enrolled)**

    - Are you age 50 - 64? (Breast Cancer Screening Priority for Mammogram and CBE)
    - Are you age 40 - 64? (Cervical Cancer Screening Priority for Pap and Pelvic exam)

- Especially who have never had a Pap test or not had a Pap test in 5 or more years
- If over age 64, are you eligible for Medicare?
  - If eligible for Medicare, have you elected Medicare Part B and paid the premium?
    - Some women over age 65 are not eligible for Medicare due to no work record – for example a wife of a sheepherder who never received wages.
    - Some women cannot afford to pay the premium for Medicare Part B, and are therefore eligible for *WHC*. (They should be strongly encouraged to enroll in Medicare Part B if at all possible since it provides much broader care than *WHC*.)

4. **Limited Enrollment and Services for women who are: (25% of those enrolled)**

   - Between the ages of 40 – 49 to qualify for breast cancer screening, women must additionally:
     - Have symptoms suspicious of breast cancer (clinician must complete approval form, Limited Enrollment Approval and submit with enrollment).
     - Have a history of breast cancer (self) for breast cancer (clinician must submit form, Limited Enrollment Approval).
     - Have NO health care insurance.

   - Between the ages of 30 – 39 to qualify for breast cancer screening, women must additionally:
     - Have symptoms suspicious of breast cancer (clinician must complete approval form, Limited Enrollment Approval and submit with enrollment).
     - Have NO health care insurance.

   - Between the ages of 30 – 39 to qualify for cervical cancer screening, women must additionally:
     - Have symptoms suspicious of or at increased risk for cervical cancer (clinician must submit form, Limited Enrollment Approval).
     - Have NO health care insurance.

5. **Prior Enrollment:**

   - In some sections of the state, coverage areas of LCC's overlap and clients may move from one LCC area to another.
     - Ask client if they have previously received *WHC* services. If yes, it is the responsibility of the LCC determining eligibility to obtain prior records before scheduling client appointments.
     - LCC can query the WHC Real Time database to determine if the client has previously enrolled at another site.

*According to federal law, men are not eligible for WHC. Although a small percentage of men may develop breast cancer, the funding for this program is intended for screening the population at increased risk of breast and cervical cancer. Population based screening for men is not recommended.

Note: Completed and signed Enrollment Form must be submitted to LCC within 24 hours. The LCC shall enter enrollment information into *WHC* electronic database within 1 week of services provided.

Healthcare Professionals

HEALTHCARE PROFESSIONALS

Women's Health Check (WHC) client services are provided through a network of Local Coordinating Contractors (LCC) and over 300 health care providers.

Through the partnership and dedication of all of the healthcare professionals that provide services and case management, *WHC* fills a critical gap in the screening and early detection of breast and cervical cancer in Idaho.

LIABILITY

Medical Malpractice and Breast Cancer Evaluation" R. James Brenner, MD, JD, FACR

"Delay in diagnosis of breast cancer is the most common reason that physicians are sued for malpractice, the most commonly named defendant being the radiologist and the greatest indemnity awards relating to primary care physicians. Reasonable clinical examinations with appropriate medical record documentation combined appropriate imaging studies and deliberate management plans form the basis for risk management. An awareness of the interaction between these two disciplines with respect to both limitations and potential of imaging and physical examination is essential to the aspect of legal liability and causation…"

Standard of care includes:

- Appropriate history and risk factors,
- Documented complete screenings and diagnostic work-up,
- Recall mechanisms in place.

Following the procedures required by *WHC*, utilizing the *WHC* electronic database and case management system will reduce the chance for delayed or missed follow-up of abnormal results. This also assists with documentation of appropriate procedures and results.

LOCAL COORDINATING CONTRACTOR REQUIREMENTS

Women's Health Check (*WHC*) client services are provided through a network of Local Coordinating Contractors (LCC) and over 300 health care providers. Each LCC contracts with the State of Idaho, *Women's Health Check* program to recruit and enlist local providers, recruit and enroll clients, obtain and record data, and to provide timely and adequate case management.

PROVIDER RECRUITMENT

- Identify and enlist qualified local providers for annual exams, mammograms, laboratory tests, and for diagnostic referrals.
- Submit names of providers to state *WHC* office for Memorandum of Agreement (MOA).
- Maintain regular communication with providers regarding changes, updates, new information, and publications relating to *WHC*.

CLIENT RECRUITMENT

- Conduct local outreach activities to recruit and enroll eligible women of priority age for screening.
- Ensure *WHC* Client Welcome and Welcome Back packets are at each enrollment site.
- Oversee client eligibility and enrollment.
- Monitor number of clients enrolled and returning for annual rescreening according to current contract.
- Utilize waiting lists to monitor enrollment of priority screening population without exceeding available resources.

RECORDS AND DATA

- Establish and maintain client records containing all required data.
- Enter data into *WHC* Real Time system.
- Ensure timely and appropriate follow-up and case management through weekly monitoring of all reports in *WHC* Real Time system.
- Ensure client data is entered as soon as available.

CASE MANAGEMENT

- Provide/oversee case management for clients with unusual needs
- Provide/oversee appropriate case management for women with abnormal test/exam results
- Ensure timely diagnosis and referral to BCC Medicaid Treatment or assist with other arrangements
- Ensure women do not "fall through the cracks" of the system by addressing barriers that prevent them from screening, diagnostic, or treatment for breast or cervical cancer
- Use due diligence to reduce the risk of litigation by:
  - Ensuring that there are no more than 60 days between abnormal findings and diagnosis, no more than 60 days between diagnosis and treatment.
  - Following standards of practice.

PROVIDER REQUIREMENTS

Women's Health Check (WHC) client services are provided through a network of Local Coordinating Contractors (LCC) and over 300 health care providers. All providers agree to utilizing approved procedures and reporting results for *WHC* clients to LCCs.

REPORTED FINDINGS

- Results of all tests and exams must be submitted to the *WHC* LCC using screening/diagnostic forms within 30 days of procedure.

REQUIREMENTS FOR TIMELINESS AND ADEQUACY

- Enrollment forms are submitted to the *WHC* LCC as soon as possible.
- Claims for exams, tests and procedures shall be submitted within 90 days to the Third Party Administrator for *WHC*. That agency will pay providers directly for qualifying service (see *WHC* eligible codes and current rates), provided by a health care provider who has a current Memorandum of Agreement with the state *WHC* office, for an enrolled *WHC* client.
- Results of all tests/consults/exams must be provided to the *WHC* Local Coordinating Contractor as soon as possible, at least within 30 days of procedure or exam.
- Mammograms and Clinical Breast Exams (CBE) are required to be within a 60 day interval.

Note: Due to limited *WHC* funding, Clinical Breast Exam, pelvic and collecting Pap specimen should be done at the same visit.

ANNUAL APPOINTMENTS

- Review client's *WHC* responsibility to keep screening and follow-up appointments. (Intake Assessment form and Enrollment form) Question client about possible barriers to getting the mammogram or other services. (Beliefs, fear, transportation, childcare etc.)
- Obtain a second contact phone number if not on Enrollment form.
- Assist client with overcoming any identified barriers.
- Provide appropriate education. (Importance of Clinical Breast Exam (CBE) together with mammogram for early detection, size of lump found by CBE alone vs. mammogram and CBE, radiation exposure no more than dental x-rays, exposed to more radiation flying coast to coast etc.)
- Make client appointment for mammogram or other services.
- Document in client record.
- Enter data in *WHC* electronic data system.

OTHER

- Client should not be billed for services covered by *WHC*. Contracting providers agree to accept the Medicare rate for the approved CPT codes.

- Any other procedures (not listed for *WHC* CPT codes) are NOT covered, and the client must be informed prior to the procedure that it will not be paid for by *WHC*. Other arrangements for payment must be made prior to any non-covered services.

- Mammography facility, lab, physician or other healthcare professional must have appropriate certification/licenses for services (ex: MQSA, CLIA-88) and code results according to ACR BI-RADS (mammography) or Bethesda system (Pap).

- *Women's Health Check* forms, or other means of documenting all data on those forms, must be completed accurately for all client services (Screening, Diagnostic, and Consultation). All data on these forms is reported by the state, without client identifiers, to the Centers for Disease Control and Prevention.

- Providers (including mammography facilities, labs, physicians and other health care professionals) must sign a written contract (Memorandum of Agreement) with the State of Idaho Department of Health and Welfare, *Women's Health Check* Program, before they can be reimbursed for services by the Third Party Administrator for *WHC*.

Note: Providers submit claims to the *WHC* Third Party Administrator, and may NOT bill the client for any portion of the listed services.

MEMORANDUM OF AGREEMENT

The Idaho Division of Health (Women's Health Check) and the undersigned Provider (page 3, this document), desire to enter into an agreement whereby the Provider will provide listed screening and diagnostic tests to women enrolled in the Women's Health Check (WHC) Program, according to the guidelines of the National Breast and Cervical Cancer Early Detection Program.

Background:

U.S. Congress passed Public Law 101-354 in 1992, creating the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Initially, the program provided education to increase early detection of these cancers. Since 1996, Idaho has been funded to reimburse providers for screening and diagnostic tests provided for eligible clients, enrolled in Women's Health Check.

A limited number of procedures may be reimbursed at Medicare rates for outpatient services (see attached list). No other services shall be reimbursed through this program. Results of all services reimbursed through WHC must be reported to the WHC Local Coordinating Contractor (Health Department or local clinic that has contracted with the State of Idaho to coordinate services and report data).

Provider Responsibilities:

The Provider acknowledges that it may have an obligation, independent of this agreement, to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, Provider shall comply with all amendments to the law and federal regulations made during the term of the agreement.

The Provider shall provide screening and/or diagnostic services as listed, for women enrolled in WHC, who are referred or in coordination with a WHC Local Coordinating Contractor (LCC). The Provider shall ensure that all services are provided by staff that are appropriately licensed for the service, according to national standards for mammography (MQSA), laboratory (CLIA-88), or professional license. The Provider shall provide proof of current insurance for Workers Compensation and Professional Liability.

The Provider shall provide listed services for WHC enrolled clients at no charge to the client. The Provider may not bill the client for any portion of covered services. The Provider must make other arrangements with the client for payment of any services not covered by WHC.

The Provider shall provide results of all services to the WHC Local Coordinating Contractor as soon as available, and within 30 days of date of service. Results shall be reported according to national standards, utilizing WHC Screening and Diagnostic Forms (see WHC e-Manual) at www.healthandwelfare.idaho.gov.

The Provider shall utilize standard form CMS-1500 or UB-92 to submit claims to WHC's Third Party Administrator, United Group Programs. Required claim information must include:

- Patient Name / Address / Date of Birth / Social Security Number (WHC unique ID number if no SSN available)
- Provider Name / Address / Tax ID Number
- CPT Code / Date of Service / Place of Service / Charges
- Name of WHC Local Coordinating Contractor where patient is enrolled
- All claims should be clearly marked: **"Idaho Women's Health Check"**
- Paper and/or electronic claims shall be submitted to United Group Programs
- For questions about a claim, Provider may contact United Group Programs at 1-800-810-9892, extension 114 (Shannon Branch)
- Claims shall be billed within 90 days of service to ensure payment
- Procedures that required pre-authorization must have the pre-authorization form attached or faxed with the claim form
- Submit all claims to:

United Group Programs, Inc.
Attention: Idaho Women's Health Check
902 Clint Moore Road, Suite 100
Boca Raton, FL 33487

Women's Health Check Responsibilities:

WHC shall provide updated e-Manual, Reimbursement Rate List for covered CPT code services (updated annually), as well as training and information relating to the program.

Local WHC Coordinators will maintain active communication with Providers serving clients they enroll and for which they have responsibility. LCCs provide required data to the state and federal program, with signed release of this information provided by the patient on the WHC Enrollment Form.

WHC shall ensure client confidentiality and HIPAA compliance for clients enrolled in the program.

Patients enrolled and screened through WHC who are later diagnosed with breast or cervical cancer may apply to receive Medicaid for treatment, as long as they meet citizenship or eligible alien standards and do not have insurance. WHC shall submit applications for this treatment to Medicaid.

WHC shall communicate pertinent clinical updates, according to NBCCEDP Policies and Procedures, to maintain program quality.

This agreement may be terminated, amended, changed, or otherwise revised by mutual agreement, at the initiation of either party, with 30 days written notice to the other party.

Upon termination of this agreement, no further claims may be submitted or paid by the Third Party Administrator or any representative of the program.

_____ _____
(Print Name and Title) (Date)

_____
(Signature)

_____
(Organization)

_____
(Complete Address with Zip Code)

_____
(Telephone Number) (Fax Number)

Signed:_____
Richard H. Schultz, Administrator Date
Division of Health
Idaho Department of Health and Welfare

Standards
Of
Care

Minimum Expected Follow-up – Breast or Cervical

- ✓ Whenever there is an abnormal, suspicious for cancer test result, a diagnostic work-up **MUST** be planned and recorded.
  - o All clients with abnormal findings receive a definitive diagnosis.
  - o All abnormal findings are resolved and reported.
- ✓ The time between the date of the abnormal test result to final diagnosis **MUST** be no more than 60 days.
  - o All diagnostic workups are resolved and reported.
- ✓ The time between the date of diagnosis and initiation of treatment **MUST** be no more than 60 days.
  - o All clients needing treatment are referred.
- ✓ In the case of unsatisfactory results, the test must be **repeated** and the results reported to *Women's Health Check.*

Clinical Breast Exam Result **Expected Follow-up:**		
Normal/Benign		Annual re-screen or Diagnostic referral based on mammogram results
Abnormal, Suspicious for Cancer	Regardless of Mammography finding:	(At least one of the following): Surgical consult/repeat CBE, ultrasound, biopsy/lumpectomy, fine needle cyst aspiration

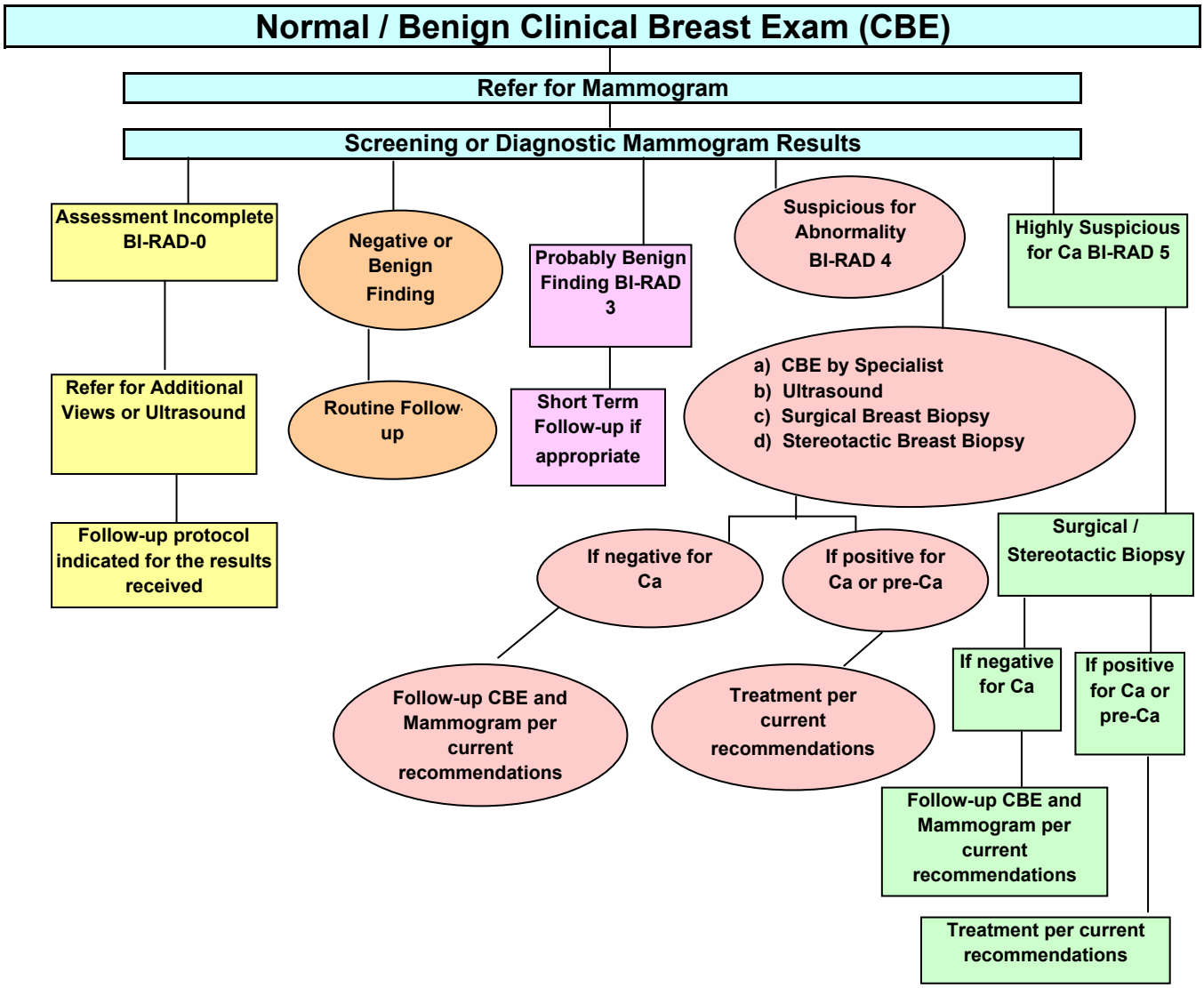
CBE/Mammography Result **Expected Follow-up:**			
CBE	**Mammogram**	**Diagnostic Procedures**	**Comments**
Normal	▪ Negative BI-RAD1 ▪ Benign BI-RAD2 ▪ Probably Benign BI-RAD 3	▪ No work-up needed, therefore adequacy need not be assessed. ▪ Short term follow-up may be recommended.	
Normal	▪ Suspicious Abnormality BI-RAD4	▪ Repeat CBE ▪ Ultrasound ▪ Biopsy / lumpectomy or Fine needle aspiration	▪ Record final diagnosis
Normal or Abnormal	▪ Highly Suggestive of Malignancy BI-RAD 5	▪ Biopsy / lumpectomy or Fine needle aspiration	▪ Record final diagnosis
Normal	▪ Assessment Incomplete BI-RAD 0	▪ Additional mammography views or Ultrasound	▪ Record final diagnosis
Abnormal, Suspicious for Cancer	▪ Negative BI-RAD1	(At least one of the following:) ▪ Surgical Consult/Repeat CBE ▪ Ultrasound ▪ Biopsy/lumpectomy ▪ Fine needle aspiration	▪ Repeat mammogram or additional views not adequate; record final diagnosis
Abnormal, Suspicious for Cancer	▪ Benign BI-RAD2 ▪ Probably Benign BI-RAD 3 ▪ Assessment Incomplete BI-RAD 0	(At least one of the following:) ▪ Surgical Consult/Repeat CBE ▪ Ultrasound ▪ Biopsy/lumpectomy ▪ Fine needle aspiration	
Abnormal, Suspicious for Cancer	▪ Suspicious Abnormality BI-RAD4 ▪ Highly Suggestive of Malignancy BI-RAD 5	▪ Biopsy or lumpectomy ▪ Fine needle aspiration	▪ Record final diagnosis

Pap Result Expected Follow-Up:		
Negative	If no work-up planned:	Adequacy need not be assessed
Infection	If work-up planned:	Requires colposcopy & final diagnosis
ASC-US	If no work-up planned:	Adequacy cannot be assessed (Repeat Pap in 6 mos, consider HPV test for women > 35)
LSIL	If work-up planned:	Requires colposcopy/bx & final diagnosis
ASC-H HSIL AGC Squamos carcinoma AIS Adenocarcinoma	**Work-up Required**	Colposcopy & biopsy, ECC if indicated
Other		Adequacy cannot be assessed

*This algorithm is not a tool for clinical decision making for individual women nor to dictate individual provider practice. It is a guide to use. Additional algorithms can be found in the *WHC* Provider Manual.

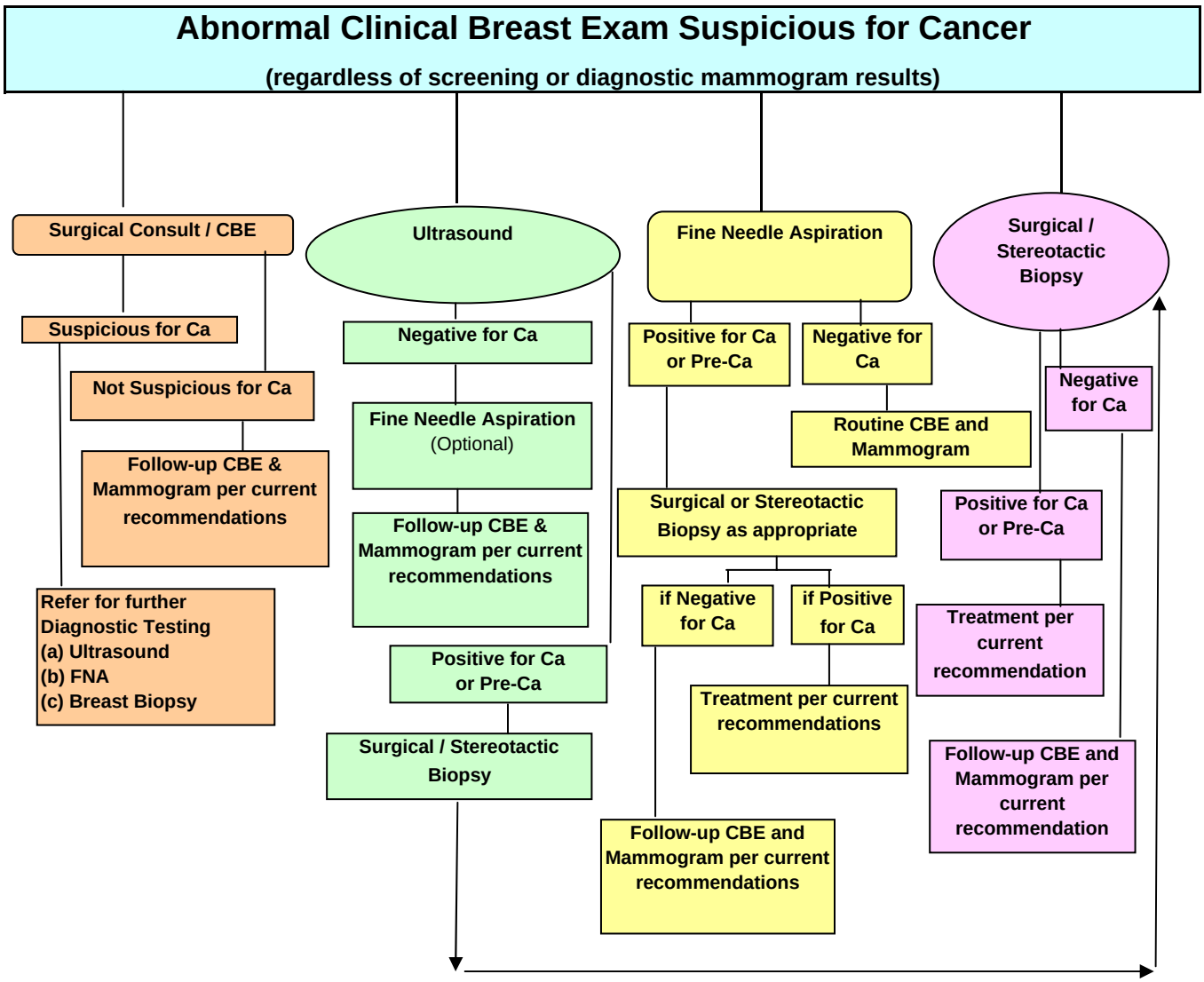
IDAHO *WOMEN'S HEALTH CHECK*

Standards of Care for Breast Cancer Screening - Algorithm 1



IDAHO *WOMEN'S HEALTH CHECK*

Standards of Care for Breast Cancer Screening - Algorithm 2

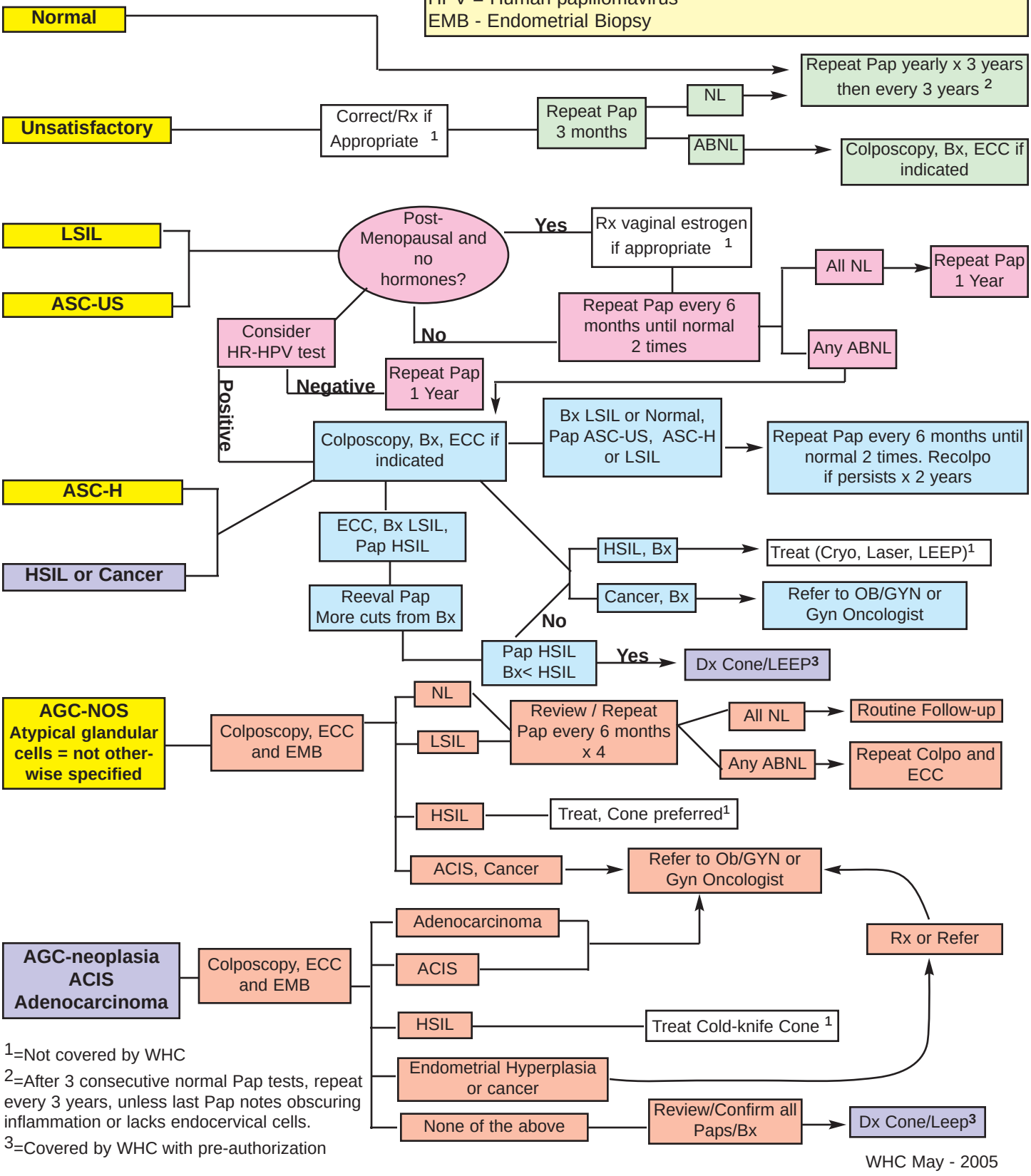


Idaho *Women's Health Check*

Cervical Cancer Screening for Women Ages 40 and Above - Algorithm 3

NL = Normal, ABNL = Abnormal
LSIL/HSIL = Low/High grade squamous intraepithelial lesion
ASC-US = Atypical squamous cells of undetermined significance
ASC-H = Atypical squamous cells - Cannot exclude High Grade SIL
AGC-NOS = Atypical Glandular Cells - Not Otherwise Specified
ACIS = Adenocarcinoma in situ
HPV = Human papillomavirus
EMB - Endometrial Biopsy

Bethesda (TBS 2) Categories



1=Not covered by WHC

2=After 3 consecutive normal Pap tests, repeat every 3 years, unless last Pap notes obscuring inflammation or lacks endocervical cells.

3=Covered by WHC with pre-authorization

WHC May - 2005

Cancer Screening and Diagnosis

ANNUAL SCREENING APPOINTMENT

The annual appointment ensures regular screening for breast and cervical cancer. Each year, client must complete a new Enrollment Form verifying current eligibility (income, insurance, age). Local staff initial form to verifying eligibility after asking key eligibility questions. Client provides contact name and number, indicates race/ethnicity and signs consent. If client is younger than priority screening age and has received normal diagnostic test or exam results, she may be determined inactive until priority screening age is reached.

Clinical breast exam (CBE) and Pap should be performed at the same visit. If prior screening services were provided at different times, schedule next services based on when next mammogram or CBE are due and delay pap until annual office visit unless client has developed symptoms associated with breast or cervical cancer.

ANNUAL SCREENING APPOINTMENT

- Determine client's eligibility using *WHC* Enrollment Form.
- Review client's *WHC* responsibility and agreement to keep screening and follow-up appointments. **(**Intake Assessment Form**)** Question client about possible barriers to getting the mammogram or other services. (Beliefs, fear, transportation, childcare etc.)
- Obtain a second contact phone number if not on Enrollment Form.
- Assist client with overcoming any identified barriers.
- Provide appropriate education. (Importance of Clinical Breast Exam (CBE) together with mammogram for early detection, size of lump found by CBE alone vs. mammogram and CBE, radiation exposure no more than dental x rays, exposed to more radiation flying coast to coast etc.)
- Make client appointment for mammogram or other services.
- Document in client record.
- Enter data in *WHC* Real Time data system (WHCRT).

ANNUAL RE-SCREENING PROTOCOL

Re-screening: The process of returning for a yearly breast or cervical cancer screening test. After 3 consecutive years of normal Paps, the interval for cervical re-screening is every 3 years. (Women over 30).. If client is younger than priority screening age and has received normal diagnostic test or exam results, she may be determined inactive until priority screening age is reached.

In order for a woman to be eligible for re-screening, she must meet all eligibility guidelines (each year). Each enrollment site has "Welcome Back" packets available which contain the appropriate forms to determine eligibility. The *Women's Health Check (WHC)* Enrollment Form must be completed, signed and submitted to the program annually.

- Scheduling clients for re-screening for breast and cervical cancer is the responsibility of all providers. Providers may use a computerized or manual system for this activity. The *WHCRT* can generate lists of women due for re-screening.

- Local Coordinating Contractor (LCC), shall notify all clients in advance of the recommended rescreening dates. If no appointment is made after the first notification, a second attempt shall be made. Documentation of the notifications shall be retained in the client record.

- *Women's Health Check* LCCs are required to use *WHCRT* for data entry tracking and follow-up.

Note: CBE and Pap should be performed at the same office visit. If there were prior screening services at different times, schedule according to when next mammogram or CBE are due and delay Pap until next annual office visit, unless at high risk. Funds provide for one office visit for CBE and pap. Clients who have had CBE, mammogram, and pap at different times need to have these services coordinated when re-screened.

REQUIRED SCREENING SERVICES - BREAST

Women's Health Check (WHC) provides annual breast cancer screening for women of priority age.

Note: According to federal law, men are not eligible for WHC. Although a small percentage of men may develop breast cancer, the funding for this program is intended for screening the population at increased risk of breast and cervical cancer. Population based screening for men is not recommended.

The following services are required for a complete screening:

WHC BREAST CANCER SCREENING

Priority Population:
Qualifying women aged 50 - 64 are eligible for:

- Annual clinical breast examination (CBE) and mammogram for a complete screening.
- Diagnostic tests or Consultation by Breast Specialist as listed in WHC schedule of eligible CPT codes, if needed.

Limited enrollment based on funding is available for qualifying uninsured women under age 50 for:

- Clinical breast examination (CBE) if determined medically necessary due to abnormal test or exam results.
- Mammogram if determined medically necessary due to abnormal test or exam results.
- Diagnostic tests or Consultation by Breast Specialist as listed in WHC schedule of eligible CPT codes, if needed.

Limited Enrollment Approval Form must be completed and submitted to LCC.

Note: Due to *WHC* funding, Clinical Breast Exam, pelvic and Pap test should be done at the same visit.

WHC encourages women to have complete screening for both breast and cervical cancer; however, women can be in the program for just breast or cervical cancer screening. Women under age 50 must meet enrollment criteria for each segment (breast or cervical) separately and may not receive annual tests if diagnostic test or exam results are normal.

PRIOR ENROLLMENT:

In some sections of the state, coverage areas of LCC's overlap and clients may move from one LCC area to another.

- Search for client in WHC Real Time data system. If the client has been previously enrolled with another LCC, it is the responsibility of the LCC determining eligibility to request a transfer before scheduling client appointments.

Note: Completed and signed Enrollment Form must be submitted to LCC within 24 hours. The LCC shall enter enrollment information into the WHC Real Time data system within 1 week of services provided.

REQUIRED SCREENING SERVICES - CERVICAL

Women's Health Check (WHC) provides annual cervical cancer screening for women of priority age.

The following services are required for a complete screening:

WHC CERVICAL CANCER SCREENING

Priority Population:
Qualifying women (with an intact cervix) aged 40 – 64, especially those have not had a Pap test in the past 5 or more years, are eligible for:

- Annual pelvic examination.
- Annual Pap test.
- Diagnostic services if initial cervical cancer screening (Pap test) is abnormal (done at a participating *WHC* provider).

Limited enrollment based on funding is available for qualifying uninsured women ages 30 – 39 for:

- Annual pelvic and Pap test until three normal Pap tests are documented. .
- Diagnostic services if initial cervical cancer screening (Pap test) is abnormal (done at a participating *WHC* provider).
- Limited Enrollment Approval Form must be completed and submitted to LCC.

Note: After three (3) consecutive normal Pap tests, reimbursement for a Pap test is every three (3) years.

Women who have had a Hysterectomy:

- Due to cervical cancer or neoplasia, continue to be eligible for regular cervical cancer screenings.
- Performed for any other reason will be eligible for one pelvic exam to confirm the presence or absence of the cervix. If there is no cervix, she is not eligible for cervical cancer screening.

Note: Due to *WHC* funding, Clinical Breast Exam, pelvic and collecting Pap specimen should be done at the same visit.

WHC encourages women to have complete screening for both breast and cervical cancer; however, women can be in the program for just breast or cervical cancer screening. Women under age 50 must meet enrollment criteria for each segment (breast or cervical) separately, and will not continue annual screening if diagnostic tests have normal results.

PRIOR ENROLLMENT:

In some sections of the state, coverage areas of LCC's overlap and clients may move from one LCC area to another.

- Search for client in WHC Real Time data system. If the client has been previously enrolled with another LCC, it is the responsibility of the LCC determining eligibility to request a transfer before scheduling client appointments.

Note: Completed and signed Enrollment Form must be submitted to LCC within 24 hours. The LCC shall enter enrollment information into the WHC Real Time data system within 1 week of services provided.

DIAGNOSTIC SERVICES

Women's Health Check provides for screening and diagnostic services. The following diagnostic tests, as listed in schedule of eligible CPT codes for this program are offered:

WHC DIAGNOSTIC SERVICES – BREAST

- Repeat CBE and/or mammogram
- Fine needle aspiration (FNA)
- Ultrasound
- Core needle biopsy
- Stereotactic breast biopsy
- Incisional and excisional biopsies
- Specialist consultation
- Anesthesia associated with biopsy

WHC DIAGNOSTIC SERVICES – CERVICAL

- Repeat Pap test and pelvic examination
- Colposcopy (with or without biopsy)
- Endocervical curettage (ECC) – colposcopy as directed
- Specialist Consultation
- HPV, Amplified Probe
- Endometrial Sampling
- Diagnostic LEEP, conization for definitive diagnosis – *Pre-approval from state WHC office required*

Services not listed in schedule of eligible CPT codes will not be reimbursed by WHC. The program does not cover blood tests, MRI, CT, Abdominal Ultrasound and other services that may be commonly prescribed.

Note: Local Coordinating Contractor (local Health District or contracting agency) will assist with case management and follow-up of clients with abnormal screening results or who have other major barriers to obtaining eligible services.

WHC PROGRAM CRITERIA FOR DIAGNOSTIC CONIZATION OR LEEP PROCEDURES:

Note: Requires pre-authorization on an individual client need basis. Contact the state WHC office. (Jeanie Scepka at 208- 334-5971.)

BACKGROUND

- Centers for Disease Control and Prevention issued a new policy in June, 2004, based on the proceedings of the American Society of Colposcopy and Cytopathology (ASCCP) Consensus Conference on Management of Abnormal Cervical Cytology Reports (2001).
- The policy allows for use of NBCCEDP (federal program) funds for loop electrode excision procedure (LEEP), laser conization, and cold-knife conization.

CRITERIA FOR WHC REIMBURSEMENT

- LEEP or cold-knife conization of the cervix may be reimbursed as a diagnostic procedure when colposcopy does not demonstrate a definitive diagnosis.
- See the ASCCP recommendations on management of women with high-grade intraepithelial lesions (HSIL) which must be followed.

SATISFACTORY COLPOSCOPY:

- When no lesion or only biopsy-confirmed CIN I is identified after satisfactory colposcopy in women with HSIL Pap test reports, it is recommended that a review of the colposcopy, Pap, and histology results be performed.
- If the review yields a revised interpretation, management should follow guidelines for the revised interpretion.
- If a cytological interpretation of HSIL is upheld, a diagnostic excisional procedure is preferred in non-pregnant patients.
- A colposcopic reevaluation with endocervical assessment is acceptable in special circumstances such as when CIN II or III is not found in a young woman of reproductive age or during pregnancy when invasive cancer is not suspected.

UNSATISFACTORY COLPOSCOPY:

- When no lesion is identified after unsatisfactory colposcopy in women with HSIL, a review of the cytology, colposcopy, and histology results should be performed when possible.
- If the review yields a revised interpretation, management should follow guidelines for the revised interpretion.

- If a cytological interpretation of HSIL is upheld, review is not possible, or biopsy-confirmed CIN I is identified, a diagnostic decisional procedure is recommended in non-pregnant patients.
- Ablation is unacceptable.
- During pregnancy, if initial colposcopy is unsatisfactory, it may become satisfactory later in pregnancy and so should be repeated within 6-12 weeks.
- Omission of endocervical sampling is acceptable when a diagnostic excisional procedure is planned.
- In women with HSIL in whom colposcopy suggests a high-grade lesion, initial evaluation using a diagnostic excisional procedure is also an acceptable option.
- Triage using either program of repeat cytological testing of HPV DNA testing is unacceptable.

Approval for Diagnostic LEEP or Conization*

Submit for Pre- Authorization. Attach copies of pertinent reports.
Request must be based on need for definitive diagnosis not demonstrated by colposcopy.

Client Name: _____ **Age:** _____ **D.O.B.** _____

❒ **Satisfactory Colposcopy**

- ❒ **No lesion or only biopsy confirmed CIN I identified with HSIL Pap**
- ❒ **Colposcopy and histology reports reviewed (when possible), no new interpretation, HSIL upheld**
  - **Result and Date of prior cytology(Pap)** _____
  - **Result and Date of prior histology (biopsy)** _____

❒ **Unsatisfactory Colposcopy**

- ❒ **No lesion identified in client with HSIL Pap**
- ❒ **Colposcopy and histology reports reviewed - no new interpretation, HSIL upheld**
  - **Result and Date of prior cytology (Pap)** _____
  - **Result and Date of prior histology (biopsy) or ECC** _____

❒ **Unexplained Atypical Glandular Cells – neoplastic or worse**

- ❒ **Pap reviewed and AGC-neoplastic, ACIS, or adenocarcinoma confirmed**
- ❒ **Colposcopy, cervical biopsy if any, ECC, and EMB reviewed - no HSIL, ACIS, invasive carcinoma, endometrial hyperplasia, or endometrial cancer found**
  - **Result and Date of prior cytology (Pap)** _____
  - **Result and Date of prior histology (biopsy), if applicable** _____
  - **Result and Date of prior ECC** _____
  - **Result and Date of prior EMB** _____

Comments:_____

_____

_____

_____

❒ Based on information documented above, this client is at high risk and LEEP or Conization is recommended for definitive diagnosis.

Clinician: _____ **Title:** _____ **Phone:** _____ **Date:** _____

Contracting Clinic: _____

Local Case Manager:

Name _____

Title_____ **Date** _____

Approved by WHC State Office:

Name _____

Title_____ **Date** _____

CPT Codes for Reimbursement*:

57460 – colposcopy of the cervix with loop electrode biopsy(s) of the cervix

57461 – colposcopy with loop electrode conization of the cervix

57520 – conization of cervix, with or without fulguration, with or without dilation and currettage, with or without repair; cold knife or laser

57522 – loop electrode excision

58100 – Endometrial Sampling with or without Endocervial Sampling

00940 – Anesthesia Fees related to Approved Cervical Procedures

***THIS FORM MUST BE ATTACHED to CLAIM SUBMISSION for REIMBURSEMENT**. 6.06

Treatment

TREATMENT SERVICES

Only women who have been screened and diagnosed with breast or cervical cancer or neoplasia through Women's Health Check (*WHC*) may qualify for treatment through BCC Medicaid.

- The client must be under age 65, be a U.S. citizen or eligible alien, reside in Idaho and have no creditable insurance.
- The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA - the Act) (**Public Law 106-354**) provides treatment through Medicaid for women who have been screened and diagnosed with breast or cervical cancer through *Women's Health Check*.

Note: More information about BCC Medicaid and Treatment can be found under Case Management, BCC-Medicaid.

Case Management

CASE MANAGEMENT

Case management is a system of assessment, planning, coordination, monitoring, evaluation, and resource development. Once a woman with an abnormal screening result is identified, she should be assessed for medical and social services needs as well as barriers impeding her access to diagnostic and/or treatment services.

In special instances, case management (CM) can be provided to women who have previous history of abnormal findings, screening which requires short-term follow-up, and/or do not respond to re-screening reminders.

GOAL

To ensure that women enrolled in the program receive timely and appropriate diagnostic, treatment and re-screening services.

Note: There should be no more than 60 days between the time an abnormal finding is identified and final diagnosis. There should be no more than 60 days between diagnosis and initiation of treatment.

INTAKE ASSESSMENT FORM

- **Must be completed on all clients at the time of enrollment** to insure client understands and agrees to terms of participation in *Women's Health Check(WHC)* and to identify any client barriers to service. The Intake Assessment form should be maintained by local case manager in client file, with a copy given to client upon enrollment
- Provides assessment of any barriers to obtaining and completing services
- **Provides notice to client that non-covered services are not paid by the program**
- Service Referral section provides location for additional services if enrolled at a site that does not provide comprehensive *WHC* services
- *WHC* clients may be referred to qualified providers for additional breast and cervical screening / diagnosis services, as long as those providers have entered into a "Memorandum of Agreement" with the state

CLOSURE

- Client should be closed to *WHC* when she is no longer eligible due to income, insurance, or becomes eligible for Medicare and secures Medicare Part B coverage (notify State *WHC* office)
- Client should be closed to *WHC* when she moves out of state (notify *WHC*)
- Case Management Services conclude when:
- Diagnostic services have been completed, no cancer diagnosis
- Treatment is initiated (Clients accepted by Medicaid for treatment should be maintained in the tracking system and notified when it is time for re-screening)

Note: All providers must be appropriately licensed, and have a contract or formal agreement with the local WHC Contractor that outlines billing, reporting of results, and that client will not be billed for eligible services.

Clinical
and
Clerical
Case Management

CASE MANAGEMENT - RN

Case management is a system of assessment, planning, coordination, monitoring, evaluation, and resource development. Once a woman with an abnormal screening result is identified, she should be assessed for medical and social services needs as well as barriers impeding her access to diagnostic and/or treatment services.

In special instances, case management (CM) can be provided to women who have previous history of abnormal findings, screening which requires short-term follow-up, and/or do not respond to re-screening reminders.

CLINICAL- RN CASE MANAGER

- Contact clients with abnormal findings who have indicated psycho-social issues as barriers on Intake Assessment Form. Provide information and support.
- Determine need and arrange for Medical Translator to accompany client to surgical consult appointment
- Contact clients with multiple diagnostic procedures, biopsy. Provide information and support. Assess for barriers.
- Review Quality Assurance reports weekly and monthly – take appropriate action to resolve, document.

Note: There should be no more than 60 days between the time an abnormal finding is identified and final diagnosis. There should be no more than 60 days between diagnosis and initiation of treatment.

- Contact clients with diagnosis of cancer or pre-cancer
  - Provide information and support. Utilize Client Diagnostic Resource materials.
  - Make arrangements to complete BCC Medicaid Application or refer if not eligible
- Complete Medicaid Application forms
  - Include biopsy report and other pertinent documents
  - Forward to state WHC office
  - Contact client of BCC Medicaid approval or denial – answer questions, offer support

CLERICAL/CLINICAL CASE MANAGEMENT RESPONSIBILITIES

- Review Abnormal Reports with RN
- Take appropriate action – determine reason for appointments not kept, reschedule. Obtain reports
- Refer problems to RN when appropriate (fear, denial, refusal etc.)
- Refer clients with multiple diagnostic procedures, biopsies to RN
- Ensure client access to resource/education materials
- Clients with diagnosis of cancer to RN for case management and Medicaid Application or other treatment referral

CASE MANAGEMENT - CLERICAL

Case management is a system of assessment, planning, coordination, monitoring, evaluation, and resource development. Once a woman with an abnormal screening result is identified, she should be assessed for medical and social services needs as well as barriers impeding her access to diagnostic and/or treatment services.

In special instances, case management (CM) can be provided to women who have previous history of abnormal findings, screening which requires short-term follow-up, and/or do not respond to re-screening reminders.

CLERICAL CASE MANAGEMENT RESPONSIBILITIES

ENTER DATA ON NEWLY ENROLLED AND RETURNING CLIENTS IN WHC REAL TIME SYSTEM (WHCTR)

- Enter same day or as soon as possible (ASAP) within 1 week of service or receipt of result
- Determine any barriers checked on Intake Assessment form and follow local protocol to address
- Include Pap and mammogram history
- Submit signed and completed enrollment forms for new and returning clients to State WHC with monthly billing
- Enter screening, diagnostic, Short Term Follow-up (STFU) results as soon as received
- Complete cycles, treatment start dates
- Print and monitor Quality Assurance Reports
- Determine reasons for missing/incomplete information – document in comment section of cycle (appointments not kept, reports not sent etc.)
- Submit Enrollment Service Monthly Checklist to State WHC office

MONTHLY PRIORITIES:

- Run reports for STFU and annual rescreen due – make appointments
- Run and review *WHCRT* reports for missing, incomplete data
- Enter missing, incomplete data.
- Document reason for missing/incomplete data and action taken, especially abnormal work ups using comments section on client demographics or cycle screens of *WHCRT*.

CLERICAL/CLINICAL CASE MANAGEMENT RESPONSIBILITIES

- Review Abnormal Reports with RN
- Take appropriate action – determine reason for appointments not kept, reschedule and document in comments section of *WHCRT*. Obtain reports
- Refer problems to RN when appropriate (fear, denial, refusal etc.)
- Refer clients with multiple diagnostic procedures, biopsies to RN
- Ensure client access to resource/education materials
- Clients with diagnosis of cancer to RN for case management and Medicaid Application or other treatment referral

CYCLE COMPLETION

Cycles are used by *WHC* to identify an appropriate end to the screening process. Most cycles are simple – screening, normal result, close cycle and notify client next year when she is due for re-screening. Abnormal screening results create more complex cycles. Cycles relate to data entry into the *WHC* electronic data system.

NORMAL RESULT

- Screening cycle begins with data on Pap smear, mammogram or Clinical Breast Exam (CBE).
- Ends with normal screening results and completed data entered into client record and *WHC* electronic data system.

ABNORMAL FINDINGS

- Screening cycle begins with data on Pap smear, mammogram or CBE.
- Diagnostic procedures and diagnosis reached, treatment started if appropriate.
- Data collected, recorded on appropriate forms and entered into *WHC* electronic data system.
- Abnormal findings, cycle does not end until diagnosis and treatment data are complete.
- Cancer not found, but follow-up needed at a later time. (This is recorded as a shorter interval than re-screening)
- Planned delay for short term follow-up/re-screen starts a new cycle.

INCOMPLETE SERVICES

- Unable to complete cycle because client moved out of area, unable to locate client or client refused services.
- Data collected, forms completed, written documentation of attempts to complete services/locate client, data entered, submitted to *WHC*.
- Inability to complete services after 3 attempts closes cycle. If cycle involves abnormal results, the final attempt shall include a certified letter to the client that identifies risks of failure to follow-up.

RE-SCREENING REMINDER SYSTEM

The *Women's Health Check* Real Time (WHCRT) system is designed to collect required data that must be reported to CDC, while also providing essential quality assurance reports to ensure appropriate and timely follow-up.

- Client enrollment information must be entered within one (1) week to ensure claims payment and treatment, if needed.
  - Enrollment sites shall fax and mail client enrollment form and client intake assessment form to Local Coordinating Contractor (LCC) as soon as enrollment form is signed and client is determined to be eligible according to age, income, and insurance.
- LCC is responsible for entering accurate and complete client data within one (1) week receiving this information.
- LCC shall review/print quality assurance reports to assist with completion of re-screening and follow-up at least every 2 weeks.

QUALITY ASSURANCE REPORTS

ABNORMAL REPORTS:

Priority 'case management/quality assurance' reports shall be reviewed at least weekly.

- **Abnormal Mamms/CBE with No Follow-up** and **Abnormal Paps with No Follow-up**: Identifies patients with an abnormal CBE/mammogram or Pap result
  - with no diagnostic result or
  - no date of a completed diagnostic follow up procedure and no final diagnosis recorded.
- **Short Term Follow-up Due:** Identifies patients recommended for return in less than 12 months
  - indicates number of months before return appointment
  - calculated from the performed date of a previous procedure with this recommendation
  - this date must fall within the dates set for return.

Note: Reports for women due for Short-term follow-up (STFU) appointments should also be addressed at least monthly.

SCREENING/SCHEDULING REPORTS:

These specific and general reports are supplemental 'case management' reports to help ensure that screening cycles are complete and timely and should be run on a periodic basis (weekly is suggested). Patients with these circumstances do not appear in the 'ALERTS' in the *WHC Real Time* data system.

- **CBE's Without Mamms**: Identifies patients who had a CBE performed within the date range of the report and no Mammogram result entered.
- **Mamms Without CBE's**: Identifies patients who had a mammogram performed within the date range of the report and no CBE result has been entered
- **Pelvic Exams Without Pap's**: Identifies patients who had a pelvic exam performed within the date range of the report and no pap result has been entered
- **Missed Appointments/Missing Results**: Identifies patients who have appointment dates entered for any service.
  - Appointments 14 days past date scheduled with no performed date or result entered

  Either the patient did not keep the appointment or the provider has not forwarded the results.
- **Appointments Scheduled**: Identifies future patient appointment dates. Enables you to run a report of appointments to occur in the future for all providers, or individual provider/clinicians

LCC ADMINISTRATION:

These reports are primarily for the administration of the Women's Health Check program. They are tools that you can use to meet Women's Health Check requirements.

- **Enrollment Services Monthly Checklist**: MUST accompany your monthly enrollment forms.
  - The total at the end of the report is the number of unique patients that had services in the month you are billing for.
  - Counts patients only once for a screening year in the month that their first service is recorded.
  - Enrollment forms and 'Under 50' forms should be arranged alphabetically, checked off and sent with this report to the WHC state office.
- **Patients in Treatment**: Identifies LCC patients who are currently on Medicaid for treatment of breast or cervical cancer.
  - Recommend running periodically (at least monthly), to determine who is due for annual screening that may not be covered by BCC Medicaid.
  - Recommend personal contact to setup their screening. The patients on this list will not be on the Reminder Mail Merge File.
  - These patients are currently inactive with our Third Party Administrator. Service providers will need a Reimbursement Request for WHC Screening Services form to accompany the claim form for the TPA to reimburse.
- **Reminder Mail Merge File**: Utilize for LCC's reminder letters
  - WHC Real Time can create reminders based on information entered into the system. Contact the WHC state office to set up a reminder system specific to your LCC population:
    - Harold Johansen
      Johanseh@idhw.state.id.us
      208.334.5572.

Note: Clients younger than priority screening age (<50 breast; <40 cervical) who have normal screening/diagnostic tests should be re-screened when reaching priority age.

INCOMPLETE SCREENING SERVICES

CDC requires complete screening. This means a Clinical Breast Exam (CBE) and mammogram for breast screening, and a pelvic exam and Pap for cervical screening. All results must be recorded in *Women's Health Check* (*WHC*) electronic data system before the screening is considered complete. The Local Coordinating Contractor (LCC) is responsible for complete screening services.

Health Care Professionals and the LCC **must** work cooperatively to ensure timely and adequate services are provided to *WHC* clients.

EXAMPLES OF INCOMPLETE SCREENING:

- CBE with no mammogram or other incomplete screening or re-screening.
- Mammogram with no CBE.
- Abnormal CBE or mammogram with no follow-up results recorded.

ACTIONS TO ENSURE COMPLETE SCREENING SERVICES

CLERICAL RESPONSIBILITIES:

- Identify unkept appointments **within two (2) weeks.** Use *WHC* electronic database reports to simplify this process.

- Contact client to determine reason for missed appointment. Document response in *WHC* electronic data system.

- Assist with overcoming barriers. Refer to Intake Assessment form and discuss transportation, language, family care, social stigma, fears and attempt to resolve identified barrier(s). This is part of case management.

- **Reschedule appointment so that interval between CBE and mammogram is <60 days.**

- If appointment not kept, or client refuses, document and close ***OR*** inform client that you will not contact her again until next year when she is due for annual re-screening. She is welcome to call for an appointment if she changes her mind.

- Document appointment (date, date of service and final result) in client record and *WHC* electronic data system.

CLINICAL RESPONSIBILITIES:

- Identify need for medical interpretation for a client who is not fluent in English language when referred to a surgeon. Arrange for appropriate medical interpretation resources.

FOLLOW-UP OF ABNORMAL FINDINGS

The most common source of malpractice litigation in the field of oncology and the second most common source of medical malpractice litigation overall (after obstetrical and birth injuries) are claims of failure to make a timely diagnosis of breast cancer. (Breast Cancer Study, Physician Insurers Association of America, Rockville, MD. June 1995.)

Note: The time from abnormal finding to final diagnosis should be no more than 60 days.

CLERICAL RESPONSIBILITIES:

- Identify appointments not kept **within one week.** Use *WHC* Real Time system to enter appointments made and review Missing Appointment/Missing Results report weekly.
- Contact client to determine reason for missed appointment.
- Assist with overcoming barriers. Refer to RN for case management if appropriate (fear of procedure, denial, etc.).
- **Reschedule appointment so the time from abnormal finding to diagnosis is ≤60 days.**
- If appointment not kept, make 3 attempts to contact (last attempt – certified letter).
- Include recommendations, review of client's responsibility, refusal form to be signed by client and returned, stamped return envelope and notice of opportunity to re-consider follow-up.
- If client verbally refuses, send certified letter.
- Document in client record, *WHC* Real Time system. **Close if no response.**
- Close cycle promptly when:
  - All screening/diagnostic results are negative, return in one year.
  - Short Term Follow-Up (STFU) scheduled (planned delay)
  - Diagnostic workup complete, cancer diagnosis
- Assist RN/Case Manager with BCC Medicaid application, if applicable.
- Enter final diagnosis and treatment start date in *WHC* Real Time system.

CLINICAL RESPONSIBILITIES

- An abnormal Clinical Breast Exam (CBE), even with a normal mammogram, requires diagnostic follow-up. See Standards of Care algorithms.
- Identify appropriate diagnostic referrals needed. See Standards of Care algorithms.
- Review abnormal reports weekly and identify measures needed to obtain timely diagnosis and treatment.
- Identify barriers needing clinical case management (fear of procedure, denial, refusal, etc.).

LOST TO FOLLOW-UP

When a Local Coordinating Contractor (LCC) is not able to contact the client via telephone or mail, client record will be closed indicating client is lost to follow-up.

ROUTINE LOST TO FOLLOW-UP (NO UNRESOLVED ABNORMAL RESULTS)

- Document in client record and *WHC* electronic data system attempt to contact failed.

- Close client record indicating client is lost to follow-up.

ABNORMAL TEST RESULTS/HIGH RISK FOR CANCER

- Make three attempts to contact - by letter and phone call (if client has one), then certified letter if no response.

- Document in client record and *WHC* electronic data system. **Close if no response.**

SHORT TERM FOLLOW-UP OR RE-SCREEN

When screening or diagnostic results indicate that a client should return sooner than her annual appointment but not needing diagnostic work-up at this time, it is tracked as Short Term Follow-Up (STFU).

- **By entering date, WHC electronic data system can generate STFU report which should be utilized to schedule STFU appointments.**
- If client verbally refuses, send registered/certified letter.
- Include recommendations, review of client's responsibility, refusal form to be signed by client and returned, stamped return envelope and notice of opportunity to re-consider follow-up.
- Document in client record, *WHC* electronic data system. **Close if no response.**

Note: For more information related to Short Term Follow-up, see the WHC Real Time User Manual.

Request for Medical Translation

Submit to WHC state office at address below.

Client Name: _____ **Age:** _____ **D.O.B.** _____

Native language _____ **Telephone** _____

Date of Appointment _____ **Time** _____**Location:** _____
Directions: _____

Reason for appointment: _____
_____
_____

Additional comments:
_____
_____
_____
_____

Person requesting translation services: _____

Translator: _____**Phone:** _____

To ensure payment, submit this request for reimbursement within 30 days to:
Terresa Doering
Women's Health Check
450 W. State St., Boise ID 83720-0036 with W 9 form
***Include W 9 form if not previously submitted**

# of hour(s) _____ @ _____ **per hour** **Total amount billed:** _____

Send payment to:
Name: _____

Address: _____

_____

Dear _____

When you decided to participate in the Women's Health Check Program, you agreed to have a yearly mammogram, clinical breast exam, and Pap test every one to three years or as recommended by your health care provider as well as any diagnostic testing recommended.

It is important to tell you that when you do not complete your screening or diagnostic testing, it limits the possibility of identifying a medical problem in the earliest stages. The earlier a breast or cervical cancer is found, the easier it is to treat. As a WHC participant, treatment is a covered benefit if you qualify.

We care about you, your health and the quality of your life. We want to make sure that you have the opportunity to take advantage of the screening and diagnostic services offered by Women's Health Check. If you need assistance or have concerns about your appointments, please let us know. We are here to help. If you have decided not to follow through on the recommended services, please sign below and return this in the envelope provided.

If you want to cancel your enrollment, you can call this office at ----------. Otherwise, we will contact you when it is time for your annual rescreening.

Sincerely,

Waiver Statement:
I certify that I have been advised of the need for further screening or medical evaluation and the consequences of not getting this evaluation. I am exercising my right to refuse any further screening or medical follow-up evaluation.

Signature _____ Date _____

Estimada _____

Cuando decidió participar en el programa *Women's Health Check* (Chequeo de Salud para Mujeres), usted acordó hacerse un mamograma anual, un examen clínico del seno y una prueba del Papanicolaou cada uno a tres años o como sea recomendado por su proveedor del cuidado de la salud como también cualquier prueba de diagnóstico recomendada.

Es importante decirle que cuando usted no completa su evaluación o prueba de diagnóstico, limita la probabilidad de identificar un problema médico en sus primeras etapas. Mientras más temprano se encuentra el cáncer del seno o el cáncer cervical, más fácil es de tratar. Como una participante del WHC, el tratamiento es un beneficio cubierto si usted califica.

Nosotros nos preocupamos por usted, su salud y la calidad de su vida. Queremos asegurarnos de que usted tiene la oportunidad de aprovechar los servicios de evaluación y de diagnóstico que ofrece el programa *Women's Health Check*. Si necesita ayuda o tiene preguntas sobre sus citas, por favor déjenos saber. Estamos aquí para ayudarla. Si ha decidido no seguir los servicios recomendados, por favor firme abajo y regrese la hoja en el sobre provisto.

Si desea cancelar su registro, usted puede llamar a esta oficina al ----------. De otra manera, le llamaremos cuando es tiempo para hacer su reevaluación anual.

Sinceramente,

Declaración de Retiro:
Yo certifico que me han aconsejado sobre la necesidad de recibir más evaluaciones o de recibir una evaluación médica y sobre las consecuencias de no recibir esta evaluación. Estoy ejercitando mi derecho de rehusar recibir más evaluaciones o de recibir evaluación médica de seguimiento.

Firma _____ Fecha _____

Dear _____

I have received the report from Dr. ---------- indicating that you have been diagnosed with breast cancer. The goal of the Women's Health Check Program is to find cancer early so that it can be treated at the earliest stage. Because you were diagnosed through this program, you are eligible for treatment through the Medicaid Program. I understand that you are planning to pursue homeopathic treatment. I support you in your choice to use any resource that you feel will be beneficial. However, this is not a service covered by Idaho Medicaid. I recommend that you not limit your treatment choices, but take advantage of the high quality, traditional treatment through our partnership with Medicaid.

We care about you, your health and the quality of your life. We want to make sure that you have the opportunity to take advantage of the treatment that is available to you in Idaho. If you decide to take advantage of the treatment available through the Medicaid program or have concerns or questions, please let me know. We are here to help. If you have decided not to follow through on the recommended services, please sign below and return this in the envelope provided.

You are welcome to return to the Women's Health Program for continued screening when you treatment is completed.

Sincerely,

Waiver Statement:
I certify that I have been advised of the need for treatment and that traditional treatment is available to me through Medicaid. I have been advised of the risks of choosing only non-traditional treatment. I am exercising my right to refuse traditional treatment.

Signature _____ Date _____

Estimada _____

He recibido el reporte del Dr. ---------- indicando que usted ha sido diagnosticada con cáncer del seno. La meta del programa *Women's Health Check* (Chequeo de Salud para Mujeres) es la de detectar el cáncer temprano para que pueda recibir tratamiento en las primeras etapas. Porque fue diagnosticada por medio de este programa, usted es elegible para recibir tratamiento por medio del programa de Medicaid. Yo comprendo que usted está planeando seguir un tratamiento homeopático. Yo apoyo su decisión de usar cualquier recurso que usted sienta sea beneficioso. Sin embargo, este no es un servicio cubierto por Medicaid de Idaho. Yo le recomiendo que no limite sus opciones de tratamiento, pero que tome ventaja del tratamiento tradicional de alta calidad por medio de nuestra asociación con Medicaid.

Nosotros nos preocupamos por usted, su salud y la calidad de su vida. Queremos asegurarnos de que usted tiene la oportunidad de aprovechar del tratamiento que está disponible en Idaho. Si decide aprovechar del tratamiento disponible por medio del programa de Medicaid o si tiene preocupaciones o preguntas, por favor déjenos saber. Estamos aquí para ayudarla. Si ha decidido no seguir los servicios recomendados, por favor firme abajo y regrese la hoja en el sobre provisto.

Es bienvenida de regresar al programa de *Women's Health* para continuar sus evaluaciones cuando termine su tratamiento.

Sinceramente,

Declaración de Retiro:
Yo certifico que me han aconsejado sobre la necesidad de recibir tratamiento y que el tratamiento tradicional me está disponible por medio de Medicaid. Me han notificado de los riesgos de escoger sólo tratamiento no tradicional. Estoy ejercitando mi derecho de rehusar el tratamiento tradicional.

Firma _____ Fecha _____

Quality Assurance and Quality Improvement

REQUIRED DATA[1]

The collection, analysis, and use of quality data are essential for guiding program efforts. To meet Centers for Disease Control and Prevention's data management expectations, a grantee is required to

- Establish and maintain a data system for collecting, editing, and managing the data needed to track a woman's receipt of screening, rescreening, diagnostic, and treatment services.
- Establish mechanisms for reviewing and assessing the completeness, accuracy, and timeliness of data collected.
- Establish protocols to ensure the security and confidentiality of all data collected.
- Collaborate with other existing systems to collect and analyze population-based information on breast and cervical cancer, including incidence and mortality rates, cancer stage at diagnosis, and the demographic profile of cancer patients.

NBCCEDP RESEARCH AND EVALUATION

The data collected by the NBCCEDP facilitate the identification, analysis, and resolution of important issues in the provision of breast and cervical cancer screening to underserved women. Each grantee submits to CDC minimum data elements (MDEs) that are useful for planning and evaluation functions and as a basis for scientific studies. Researchers have used MDEs to examine such issues as how frequently Pap tests are needed once a series of tests are reported as negative, differences in screening mammography between the United States and the United Kingdom, and racial and ethnic differences in screening outcomes. Additionally, analysis of NBCCEDP data has been valuable in determining that linkage of the MDEs with state cancer registries is important in consistently and accurately reporting cancer-stage data. This has led to greater cooperation between units in the health departments and from the community at large.

Of equal importance is the contribution of the MDE data set to public health practice. Designed to monitor the extent to which funded programs in the NBCCEDP achieve the objectives of the authorizing legislation, the MDEs provide demographic, service, and outcome data that have had a dramatic impact on policy and program development. For example,

Descriptive reports of MDE data allow CDC to quickly identify programs struggling to meet clinical or service standards set for the national program and provide technical assistance before quality declines. These reports also guide the development of training for grantees and contribute to the identification of best practices for dissemination.

Monitoring the MDEs may result in the identification of common deficiencies that suggest that system-wide changes are needed. New national policies or partnerships may result. An example is the relationship CDC has developed with the Migrant Clinicians' Network to enhance the cancer-related case management of migrant, homeless, and mobile people.

Quality assurance (QA) is a major outcome of effective use of MDEs. Grantees can evaluate the work of individual providers against a standard and identify outliers for whom QA interventions may be needed. The MDE system provides essential information on the timeliness, adequacy, and appropriateness of follow-up of clinical care ensuring that problems are addressed and changes made.

Outcomes of MDE reporting activities have resulted in significantly increased funding, allowing additional women to be screened nationwide for breast and cervical cancer. In addition, MDE data are useful in evaluating and influencing the development of updated national cancer screening recommendations and guidelines, tracking cancer rates among women who are never or rarely screened, testing the efficacy of screening technologies, and developing models to address other cancers. Data from the NBCCEDP support performance-based budgeting and the effective stewardship of taxpayers' dollars and public trust.

Data about who is being served, with what services, within what time frame, and with what results allow CDC and its partners to assure the public that the NBCCEDP provides high-quality services to eligible women and contributes significantly to the reduction of the breast and cervical cancer burden in the country.

[1]Centers for Disease Control and Prevention. *The National Breast and Cervical Cancer Early Detection Program 1991–2002 National Report*. Atlanta (GA): Department of Health and Human Services; 2005.

BCC Medicaid

BCC MEDICAID TREATMENT SERVICES

Only women who have been screened and diagnosed with breast or cervical cancer or neoplasia through Women's Health Check (*WHC*) may qualify for treatment through BCC Medicaid.

- The client must be under age 65, be a U.S. citizen or eligible alien, reside in Idaho and have no creditable insurance.
- The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA - the Act) (**Public Law 106-354**) provides treatment through Medicaid for women who have been screened and diagnosed with breast or cervical cancer through *Women's Health Check*.

Note: It is the responsibility of the Local Coordinating Contractor (LCC) Case Manager to counsel clients who are not eligible for BCC Medicaid regarding other resources.

RESPONSIBILITIES FOR LCC CASE MANAGERS:

- Obtain documentation of diagnosis (pathology report).
- Obtain initial treatment plan (i.e. appointment with surgeon, oncologist, radiologist)
- Schedule appointment with client:
  - Complete forms with client
    - Presumptive Eligibility (PE) Form
    - Breast and Cervical Cancer Medicaid Verification (BCC-Medicaid) Form
  - Provide diagnostic education materials and opportunity for questions. Identify any barriers to following thru with treatment plan.
  - Ensure that client understands diagnosis and treatment plan and has access to resources.
  - Submit (fax, scan or e-mail) complete application **immediately** to WHC State Office:
    - FAX (cover sheet and forms) to 208-334-0657
    - E-mail to: scepkaj@idhw.state.id.us or slaughtl@idhw.state.id.us

Note: It is a high priority to request and obtain final diagnosis within a week and submit completed BCC Medicaid application IMMEDIATELY.

BCC-MEDICAID APPLICATION – INSTRUCTIONS

It is the responsibility of the Local Coordinating Contractor (LCC) Case Manager to facilitate the BCC-Medicaid Application process.

- The client must be under age 65, be a U.S. citizen or eligible alien, reside in Idaho and have no creditable insurance.

INSTRUCTIONS FOR LCC CASE MANAGERS TO COMPLETE BCC-MEDICAID APPLICATION:

1. Complete following required BCC-Medicaid forms with client:

   - Presumptive Eligibility (PE) Form, Idaho – Medicaid
     - LCC Case Manager completes and signs, client signs
       - Obtain Initial Plan of Care and Treatment Start Date from the diagnosing physician or surgeon / specialist.
       - Print physician(s) name(s) and telephone number(s) to be legible.
   - Breast and Cervical Cancer Medicaid Verification - page one only unless client has insurance
     - Part 1 must be signed by client
     - Part 2, Section 1
       - If no insurance, client checks box and signs. No further information needed
       - If insured, complete information (client and Case Manager)
     - Second page (Part 2, Section 2)
       - will be completed by Bureau of Medicaid Programs and Resource Management only if client indicates insurance source

Note: It is the responsibility of the LCC Case Manager to complete the Presumptive Eligibility and BCC-Medicaid forms.

2. Submit above required forms along with following Women's Health Check (*WHC*) forms to *WHC* State Office Via Confidential FAX 208.334.0657. Use cover sheet check list.

   - Idaho *WHC* Enrollment Form – signed by client
   - Limited Enrollment Approval Form, if applicable
   - Idaho *WHC* Screening Forms – (tests performed, dates, and results). Include reports from diagnostic services (i.e., pathology, surgical consult, radiology).

Note: Make sure information is complete on all forms. Submission of incomplete documents delays the BCC-Medicaid application process.

FOLLOWING BCC-MEDICAID APPLICATION SUBMISSION:

- Notification of BCC Medicaid Acceptance or Denial
  - Notification is sent to the LCC Case Manager
  - If accepted, a Medicaid ID number and date of eligibility are indicated.
  - *WHC* staff (local) notifies provider of Medicaid ID # for billing purposes
  - *WHC* - can be billed for approved diagnostic codes
  - Medicaid - is to be billed for treatment related services

NOTIFICATION OF CLOSURE TO BCC MEDICAID

- Notification is sent to the LCC Case Manager by state *WHC* office.
- LCC:
  - Contact client to determine *WHC* eligibility, need for post-treatment follow-up and when client should return for re-screening.
  - Schedule appropriate appointments

WHC REQUIREMENTS FOLLOWING BCC MEDICAID CLOSURE:

- Client must complete new enrollment form
- LCC:
  - Notify state office of enrollment so that Third Party Administrator can be notified;
  - Add client to Third Party Administrator list and submit to state office with enrollment form.

Note: If client is not "re-activated", *WHC* provider reimbursement will be denied.

BCC-MEDICAID CLIENTS NEEDING ANNUAL BREAST OR CERVICAL CANCER SCREENING:

- Office visit for CBE and Pap can be covered by *WHC*.
- New enrollment form is not needed.
- Notify Third Party Administrator with reimbursement request form to prevent denial of claims.

BCC-MEDICAID APPLICATION COVER SHEET

All documents must be complete, signed and LEGIBLE

Check to make certain that all of the following are included with BCC Medicaid Application:

- ☐ WHC Enrollment form (current)
- ☐ Under 50 approval – (if applicable)
- ☐ Presumptive Eligibility form
    - Breast or cervical cancer section –
        - date and result of Pap/ CBE /Mammogram
        - **date and result of biopsy,** final diagnosis
    - Initial plan of care
    - Treatment start date if known – or TB Determined
    - Physician name(s) and phone numbers
    - Case Manager's signature and phone number
- ☐ BCC-Medicaid Verification form (citizenship/insurance status)
    - Signed and dated by client (in 2 places)
- ☐ Alien document with **Alien ID #** (if non- citizen)
    - Copy front and back
- ☐ Screening, Abnormal Follow-Up forms, pathology (**biopsy**) report, other relevant reports notes

Applications without a biopsy report are not valid.

Idaho Department of Health and Welfare **11-02-04**

ATTN: Benefit Program Operations **Phone: (208) 334-5818** **Fax: (208) 334-4916**

Breast and Cervical Cancer
Medicaid Verification

Part 1: Citizenship/Alien Status Declaration
(The potentially eligible woman must complete the following information)

The information we need does not stop or limit the services you receive from Women's Health Check. We need the information to figure your eligibility for Medicaid help with all your health costs. You are not required to apply for Medicaid. The information you give us for Medicaid will not be reported to the U.S. Department of Homeland Security's Bureau of Citizenship and Immigration Services, formerly known as Immigration and Naturalization Service (INS).

Name: _____ **SSN:** _____
(Please print)

☐ **I am a U.S. citizen.**

☐ **I am not a U.S. citizen. My Alien ID # is** _____

➔ **Copy both sides of Alien ID card and attach.**

Signature: _____ **Date:** _____

Part 2: Request for Creditable Insurance Determination
(The person determining eligibility completes the following information)

Most health coverage is creditable coverage, including prior coverage under a group health plan (including governmental or church plan), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program, a program of the Indian Health Services, a State high risk pool, the Federal Employee Health Benefit Program, a public health plan, and a health benefit plan provided for Peace Corps members. Creditable coverage does not include coverage consisting solely of excepted benefits such as coverage only for accidents, disability income insurance, liability insurance, supplemental policies to liability insurance, worker's compensation insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or limited-scope dental, vision, or long-term care insurance. There may also be limited circumstances where a woman has creditable coverage, but she is not actually covered for treatment of breast or cervical cancer. For example, if a woman has creditable coverage but is in a period of exclusion (such as preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer, she is not considered covered for this treatment. If a woman who has creditable coverage exhausts her lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer, she is not considered covered for this treatment. In these circumstances, the woman may be eligible for Medicaid coverage.

Section 1:

☐ **I do not have health insurance. Signature:** _____ **Date:** _____

☐ **I do have health insurance.** ***Please complete the information below:***

Please complete this form and attach a copy of the insurance card. Incomplete forms will be returned to WHC.		
Name of Subscriber	**SSN of Subscriber**	**Birth Date of Subscriber**
Name of Insurance Company	**Phone Number of Insurance Company**	**Copy of Insurance Card (front and back)**
Full Name of Potentially Eligible Woman	**Birth Date of Potentially Eligible Woman**	**Case Number of Potentially Eligible Woman**

Section 2: To be completed by Medicaid

Date Received:	**Spoke With:**
Does The Insurance Policy Cover:	
In-Patient Care:	**Lab/X-Ray Services:**
Out-Patient Care:	**Physician Services:**
Is the potentially eligible woman in a period of exclusion for breast or cervical cancer treatment?	**Has the potentially eligible woman exhausted her lifetime limit on all benefits under the plan/coverage?**

Comments:

This insurance should ____ should not ____ be considered a creditable insurance.

Reviewed by: _____ Date: _____.

Departamento de Salud y Bienestar de Idaho **11-02-04**

ATTN: Operaciones del Programa de Beneficios **Teléfono: (208) 334-5818** **Fax: (208) 334-4916**

Cáncer del Pecho y Cuello Uterino
Verificación de Medicaid

Parte 1: Declaración del Estado de Ciudadanía/Extranjero
(La mujer potencialmente elegible debe completar la siguiente información)

La información que nosotros necesitamos no impide o limita los servicios que usted recibe del Control de la Salud para las Mujeres (Women's Health Check). Necesitamos la información para pronosticar su elegible para la ayuda de Medicaid con todos los costos de su salud. No se le requiere que solicite Medicaid. La información que nos de para Medicaid no será reportada al Departamento de Seguridad de la Nación de EE.UU. Agencia de Servicios de Inmigración y Ciudadanía, anteriormente conocida como Servicios de Inmigración y Naturalización (INS).

Nombre: _____ **NSS:** _____
(Por favor escriba en letra de molde)

☐ **Yo soy ciudadano de EE.UU.**

☐ **Yo no soy ciudadano de EE.UU. Mi # de ID de Extranjero es** _____

➔ **Copie ambos lados de la tarjeta de ID de Extranjero y adjúntela.**

Firma: _____ **fecha:** _____

Parte 2: Solicitud una Determinación de Seguro Acreditado
(La persona que determina la elegibilidad completa la siguiente información)

La mayoría de coberturas de salud son coberturas acreditadas, incluyendo coberturas previas bajo un plan de salud en grupo (incluyendo planes gubernamentales o de la iglesia),cobertura de seguro médico (ya sea en grupo o individuales), Medicare, Medicaid, programa de seguro médico patrocinado por militar, un programa de los Servicios de Salud para los Indios Nativos, un grupo del alto riesgo Estatal, el Programa Federal de Beneficios de Salud para los Empleados, un plan de salud publica, y un plan de beneficios de salud dado para los miembros del Cuerpo de Paz. Cobertura acreditada no incluye cobertura compuesta únicamente de beneficios exceptuados tales como cobertura solo por accidente, seguro de discapacidad de tener ingresos, seguro de responsabilidad personal, pólizas complementarias de seguro de responsabilidad personal, seguro de compensación a los trabajadores, seguro del automóvil para pagos médicos, seguro únicamente para crédito, cobertura para clínicas medicas en el lugar, o seguro limitado a examen dental, de la vista, o cuidados a largo plazo. Puede también haber circunstancias limitadas donde una mujer tiene cobertura acreditada, pero ella no esta actualmente cubierta por tratamiento de cáncer cervical o del pecho. Por ejemplo, si una mujer tiene cobertura acreditada pero esta en un periodo de exclusión (tal como exclusión de condición pre-existente o un periodo de afiliación a HMO) para tratamiento de cáncer cervical o del pecho, ella no es considerada cubierta para este tratamiento. Si una mujer tiene cobertura acreditada y agota su límite vital sobre todos los beneficios bajo el plan o cobertura, incluyendo tratamiento de cáncer cervical y del pecho, ella no es considerada cubierta para este tratamiento. En estas circunstancias, la mujer puede ser elegible para cobertura por Medicaid.

Sección 1:

☐ **Yo no tengo seguro médico.** **Firma:** _____ **Fecha:** _____

☐ **Yo tengo seguro medico. Por favor complete la información de abajo:**

Por favor llene esta forma y adjunte una copia de la tarjeta del seguro. Formas incompletas serán devueltas a WHC.		
Nombre del Suscriptor	**NSS del Suscriptor**	**Fecha de Nacimiento del Suscriptor**
Nombre de la Compañía de Seguros	**Número de Teléfono de la Compañía de Seguros**	**Copia de la Tarjeta de Seguro (frente y reverso)**
Nombre completo de la mujer Potencialmente Elegible	**Fecha de Nacimiento de la Mujer Potencialmente Elegible**	**Número del Caso de la Mujer Potencialmente Elegible**

Sección 2: Será completada por Medicaid

Fecha Recibida:	**Hablé Con:**
La Póliza de Seguro Cubre:	
Cuidados en el Hospital:	**Servicios de LAB/Rayos X:**
Cuidados en Consulta Externa:	**Servicios Médicos:**
¿Esta la mujer potencialmente elegible en un periodo de exclusión para tratamiento de cáncer cervical o del pecho?	**¿La mujer potencialmente elegible ha agotado su límite durante su vida de todos los beneficios bajo el plan/cobertura?**

Comentarios: _____

_____

Este seguro debería ____ no debería ____ ser considerado un seguro acreditado.

Revisado por: _____ **Fecha:_____.**

Presumptive Eligibility Form

Idaho – Medicaid

vers. (02.17.2005)

Women's Health Check
Bureau of Clinical and Preventive Services
4th Floor, PO Box 83720, BOISE, ID 83720-0036

Client Name: _____ _____ _____ **Date of Birth:** (____/___/_____)
Nombre Last (Print) First MI *Fecha de Nacimiento* Month Day Year

Age: ____ **Date of Initial WHC Enrollment:** (___/__/_____) **Social Security #:**
Edad Month Day Year *Seguro Social #* __ __ __ - __ __ - __ __ __ __

- ❑ Client apparently has no insurance that will cover treatment for this diagnosis
- ❑ Screening and Diagnostic services were provided through Women's Health Check
- ❑ Client was found to need treatment for breast or cervical cancer

Breast Cancer / Caner del Seno

Date of clinical breast exam: (____/____/_____)
Month Day Year

CBE results: _____

Date of mammogram: (____/____/_____)
Month Day Year

Mammogram results: _____

Date of biopsy: (____/____/_____)
Month Day Year

Biopsy results: _____

Final diagnosis/*Diagnóstico final*:

- ❑ Carcinoma *in situ*
- ❑ Ductal Carcinoma *in situ*
- ❑ Lobular Carcinoma *in situ*
- ❑ Invasive Breast Cancer

Cervical Cancer / Cáncer Cervical

Date of Pap Smear: (____/____/_____)
Month Day Year

Pap Smear results: _____

Date of biopsy: (____/____/_____)
Month Day Year

Biopsy results: _____

Final diagnosis/*Diagnóstico final*:

- ❑ LG SIL (CIN I/Mild dysplasia) - treatment recommended
- ❑ HG SIL (CIN II/Moderate dysplasia)
- ❑ HG SIL (CIN III/Severe dysplasia/CIS)
- ❑ Carcinoma

Initial Plan of Care / Plan Inicial de Cuidado

	Physician (Print)	**Telephone**	**Appointment Date**
❑ Surgery	_____	_____	_____
❑ Radiation	_____	_____	_____
❑ Chemotherapy	_____	_____	_____
❑ Other _____	_____	_____	_____

Treatment Start Date/ *Fecha de Inicio del Tratamiento:* (____/____/_____)
Month Day Year

❑ Client received information packet _____ *initial*

❑ Reviewed information packet with client _____ *initial*

Consent for Release of Information: I give permission to the Idaho Department of Health and Welfare to tell the local WHC program whether my Medicaid Application is approved, denied, or coverage ended for the purpose of planning for my continuing care. ***Date***: _____

☞ ***Client Signature***: _____

Consentimiento para la Liberación de Información: Yo le doy permiso al Departamento de Salud y Bienestar de Idaho para dejarle saber al programa de Women's Health Check local si mi solicitud de Medicaid ha sido aprobada, negada o si la cobertura ha terminado, para poder planear mi cuidado de salud. *Fecha* _____

Firma de la Cliente _____

The above-named client has been screened and diagnosed with breast or cervical cancer through the Women's Health Check (WHC) program, a part of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), and is applying for Medicaid as a special group recognized through the BCCPTA.

_____ _____ _____
Certified by (Women's Health Check, local Case Manager) Phone Date

_____ _____
Verified by (Women's Health Check, state office) Date

Claims Submission

CLAIMS SUBMISSION

Claims are paid weekly through a Third Party Administrator for annual exams, mammograms, Pap tests, and diagnostic procedures. Claims for these procedures for *Women's Health Check* (*WHC*) clients shall be submitted to the Third Party Administrator within 90 days of the date of service.

CLAIMS SUBMISSION GUIDELINES

- **Providers** (Mammography facilities, labs, clinics, physicians and other healthcare professionals) All Providers must enter into a Memorandum of Agreement (MOA) with the State of Idaho Department of Health and Welfare, *WHC* Program prior to providing or submitting claims for services.

    - Submit claims to the *WHC* Third Party Administrator for eligible *WHC* services paid at Medicare Rate within 90 days of service. Claims are submitted with customary charges but per MOA will be accept Idaho Medicare rates for services.
    - Submit claims by completing standard CMS 1500 or UB-92 forms, identifying Idaho *WHC* as payer or insurance plan name.
    - Client can not be billed for any covered service.
    - Signed MOA indicates acceptance of CPT rate as full payment for screening and/or diagnostic services.
    - Results of tests and exams must be submitted to *WHC* Local Coordinating Contractor (LCC) within 30 days from date of service.
    - Provider must advise client prior to providing any non-covered service, making alternative arrangements for payment for any service not listed as covered by *WHC* (see CPT codes).
    - A new MOA is required if the Federal Employment Identification Number (EIN) under which claims are submitted to the Third Party Administrator is changed.

- **Local Coordinating Contractors (LCC)**

    - Submit bills for services provided by your agency to the *WHC* Third Party Administrator
    - Obtain results of all *WHC* services from Providers, enter those results in WHC Reat Time (WHCRT) data system, and submit required forms to the state *WHC* office each month.
    - LCC must submit list of newly enrolled clients weekly to *WHC.*
    - LCC must ensure any new providers have signed and returned MOA to state *WHC* office prior to services being provided.

REQUIREMENTS FOR SUBMISSION OF RESULTS (DATA)

- Submission of Test Results

    - Mammography facilities, labs, physicians and other health professionals send all test or exam results to *WHC* LCC within 30 days from date of service. Screening and diagnostic forms (links) may be used to efficiently and adequately report required data.
    - LCC submits test results to the state *WHC* program using *WHCRT*.
    - Mammograms must be reported using accepted BI-RADS numerical categories.
    - Pap test results must be reported using BETHESDA categories.
    - CBE results must be reported according to categories listed on *WHCRT* or *WHC* Screening form (paper).
    - Any screening test identified as abnormal in the *WHCRT*, is considered suspicious for cancer and must receive adequate and timely follow-up (see *WHC* Screening Form) and appropriate case management.

OTHER

- This program is, by Federal Law, payor of last resort.
- Treatment – Case Manager from Local Coordinating Contractor shall assist client in applying for Medicaid or help locate any available resource to pay for treatment.

Note: Only allowable services that are specifically related to annual BCC screening or diagnostic work-up may be submitted.

REIMBURSEMENT PROCEDURE

Reimbursement for *WHC* services is provided through a Third Party Administrator. This requires all providers to officially enlist with the Idaho Department of Health and Welfare through a Memorandum of Agreement.

Submit completed Health Insurance Claim Form (CMS-1500 or UB-92) to:

United Group Programs
Attention: Idaho Women's Heath Check
902 Clint Moore Road, Suite 100
Boca Raton, Florida 33487
1.800.810.9892 ext 114

There are very limited services covered by *Women's Health Check*. To prevent denied claims, remember:

- *WHC* is not a primary payor – services are limited to mammograms, Pap tests, annual exam, and limited diagnostic tests. Refer to the current CPT code list of services covered.
- Claims (using CMS 1500 or UB-92) are completed and submitted to United Group Programs at the above address within 90 days of the date of service (per Memorandum of Agreement).
    - For conization or LEEP, the preauthorization form is completed and submitted to United Group Programs.
    - For women on BCC-Medicaid receiving annual screening through WHC, the Reimbursement Request form is completed and submitted to United Group Programs.

Note: *Women's Health Check* is billed a processing fee for all denied claims taking funds away from needed services. Being diligent in billing claims helps save money.

CLAIM DENIALS

All claims are to be submitted to the Third Party Administrator within 90 days from the date of service, but what should you do when a claim is denied on a current *WHC* client for a reimbursable services? Here is how to proceed:

- Do not resubmit claim. A system correction is needed to reprocess and pay.
- You have 60 days to refute the denial from the date of the denial letter. E-mail Harold Johansen at the state office **as soon as possible**. Johanseh@idhw.state.id.us or call 208.334.5572.
- Give the client name and reason given for denial.

- If more than 60 days have elapsed, it will be necessary to document reason for delay in writing to:

  Women's Health Check
  Attn: Harold Johansen
  P.O. Box 83720
  Boise, ID 83720-0036

The sooner the *WHC* state office is contacted, the easier it is to correct and process a claim.

NON-REIMBURSABLE SERVICES

Women's Health Check does not reimburse for the following services:

- Services provided to women prior to enrollment in *WHC*
- Services performed by a non-WHC provider
- Services provided to ineligible women (age, income, insurance, or in process of diagnosis or treatment)
- Any client service or procedure not listed on the approved CPT Code list
- Services where standards outlined in the *WHC* Standards for Breast or Cervical Cancer Screening are not met
- Screening services that are incomplete (CBE without mammogram, Pap with inadequate specimen)
- Services for any disease or medical condition other than breast or cervical cancer early detection

All test or exam results must be reported to the appropriate *WHC* Local Coordinator Contractor (LCC) within 30 days from date of service.

Note: Treatment is not a covered service through *WHC*, however women screened and diagnosed with breast or cervical cancer are eligible for treatment coverage through Medicaid if they are under age 65, a U. S. Citizen or eligible alien, reside in Idaho, and have no creditable insurance.

REIMBURSEMENT PROCEDURE

Reimbursement for *WHC* services is provided through a Third Party Administrator. This requires all providers to officially enlist with the Idaho Department of Health and Welfare through a Memorandum of Agreement.

Submit completed Health Insurance Claim Form (CMS-1500 or UB-92) to:

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- *WHC* is not a primary payor – services are limited to mammograms, Pap tests, annual exam, and limited diagnostic tests. Refer to the current CPT code list of services covered.
- Claims (using CMS 1500 or UB-92) shall be completed and submitted to United Group Programs at the above address within 90 days of the date of service (per Memorandum of Agreement).

Note: *Women's Health Check* is billed a processing fee for all denied claims taking funds away from needed services. Being diligent in billing claims helps save money.

D. WOMEN'S HEALTH CHECK REIMBURSEMENT RATES 2006

PRIMARY CPT	ALLOWABLE CPT*	PROCEDURE	GLOBAL RATE	TECHNICAL COMPONENT	PROFESSIONAL COMPONENT
10021		FINE NEEDLE ASPIRATION; WITHOUT IMAGING GUIDANCE	$132.10		
10022		FINE NEEDLE ASPIRATION; WITH IMAGING GUIDANCE	$145.74		
19000		PUNCTURE ASPIRATION OF CYST OF BREAST;	$107.82		
19001		PUNCTURE ASPIRATION CYST BREAST; EA ADD CYST	$27.14		
19100		BX BREAST; PERQ NDLE CORE W/O IMAG GUID-SEP PROC	$130.73		
19101		BIOPSY OF BREAST; OPEN INCISIONAL	$301.15		
19102		BX BREAST; PERCUT NEEDLE CORE USING IMAGING GUID	$223.47		
19103		BX BREAST; PERC-VACUUM/ROTATING DEV W/IMAG GUID	$572.48		
19120		EXC BREAST CYST TUMR/LES OPEN MALE/FEMALE 1/>	$407.18		
19125		EXC BRST CYST/LES ID PRE-OP RAD MARKR OPN; 1 LES	$437.83		
19126		EXC BRST CYST/LES OPN; EA ADD LES ID RAD MARKR	$164.46		
19290		PREOPERATIVE PLACEMENT NEEDLE LOC WIRE BREAST;	$156.70		
19291		PREOP PLCMT NDLE LOC WIRE BREAST; EA ADD LESION	$70.32		
19295		IMAG GUID PLCMT METAL CLIP PERQ DURING BREAST BX	$97.22		
57452		COLPOSCOPY CERVIX INCLUDING UPPER/ADJ VAGINA;	$111.53		
57454		COLPSCPY CERV UP/ADJ VAG; BX CERV&ENDOCERV CURET	$143.12		
57455		COLPOSCOPY CERV INCL UP/ADJ VAGINA; W/BX CERVIX	$148.76		
57456		COLPSCPY CERV INCL UP/ADJ VAG; W/ENDOCERV CURET	$140.07		
57460-	***pre-auth reg***	***ENDOSCOPY W LOOP ELECTRODE BIOPSY(S) OF THE CERVIX***	***$334.22***		
57461-	***pre-auth reg***	***ENDOSCOPY W LOOP ELECTRODE CONIZATION OF THE CERVIX***	***$369.75***		
57500		BIOPSY, SINGLE OR MULTI, OR LOCAL EXCISION OF LESION	$134.08		
57505		ENDOCERVICAL CURETTAGE (Not done as part of D&C)	$89.39		
57520-	***pre-auth reg***	***CONIZATION OF CERVIX W/WO FULGURATION OR DILATION***	***$317.77***		
57522-	***pre-auth reg***	***LOOP ELECTRODE EXCISION PROCEDURE***	***$260.06***		
58100		ENDOMETRIAL SAMPLING W/WO ENDOCERVIAL SAMPLING	$114.21		
76090	G0206	DIAGNOSTIC MAMMOGRAPHY; UNILATERAL	$76.69	$38.87	$37.82
76091	G0204	DIAGNOSTIC MAMMOGRAPHY; BILATERAL	$95.25	$48.40	$46.85
76092	G0202,0060T	SCREENING MAMMOGRAPHY BILATERAL	$83.35	$45.54	$37.81
76095		STEREOTACT GUID BRST BX/NEEDLE PLCMT-EA LES-RS&I	$351.29	$265.06	$86.23
76096		MAMMO GUID NDLE PLCMT BREAST EA LESION RAD S&I	$78.44	$48.40	$30.04
76098		RADIOLOGICAL EXAMINATION SURGICAL SPECIMEN	$24.09	$15.47	$8.62
76645		US BREAST B-SCAN &OR REAL TIME W/IMAGE DOC	$68.08	$38.87	$29.21
76942		US GUID NDLE PLCMT IMAGING SUPERVIS&INTEPR	$139.46	$103.25	$36.21
87621		INF AGT-DNA/RNA; PAPILLOMAVIRUS HUMAN-AMP	$49.04		
88141	88175	CYTOPATH CERV/VAGINAL; RQR INTEPR PHYSICIAN	$23.16		
88164	88142,88143,88147,88148,88150,88165	CYTOPATH SLIDES CERV/VAG; MNL SCR UND PHYS SUPV	$14.76		
88172		CYTOPATH FNA EVAL; IMMED CYTOHISTOLIC STUDY	$51.84	$17.27	$34.57
88173		CYTOPATH EVALUATION FINE NDLE ASPIR; INTEPR&RPT	$135.79	$56.09	$79.70
88305		LEVEL IV - SURGICAL PATHOLOGY GROSS & MICRO EXAM	$101.03	$57.55	$43.48
88307		LEVEL V- SURG PATH GROSS/MICRO EXAM	$181.68	$90.27	$91.41
88331		PATH CNSLT DUR SURG; 1ST TISS BLK W/FZ-SNGL SPEC	$90.32	$21.97	$68.35
88332		PATH CNSLT DUR SURG; EA ADD TISS BLK W/FRZN SECT	$41.72	$7.94	$33.78
99201		OFC/OUTPT VISIT E&M NEW SELF LIMIT/MINOR 10 MIN	$36.81		
99202		OFC/OUTPT VISIT E&M NEW LOW-MOD SEVERITY 20 MIN	$65.78		
99203	99204,99205,99385,99386,99387*	OFC/OUTPT VISIT E&M NEW MODERATE SEVERITY 30 MIN *Reimbursable for Medicare-Part B unenrolled women only.	$97.80		
99211		OFC/OUTPT VISIT E&M ESTAB NO PHYS PRES 5 MIN	$21.25		
99212		OFC/OUTPT VISIT E&M EST SELF-LIMIT/MINOR 10 MIN	$38.61		
99213		OFC/OUTPT VISIT E&M EST LOW-MOD SEVERITY 15 MIN	$53.11		
99214	99215,99395,99396,99397*	OFC/OUTPT VISIT E&M EST MODERATE SEVERITY 30 MIN *Reimbursable for Medicare-Part B unenrolled women only.	$83.51		
99241		OFFICE CNSLT NEW/ESTAB SELF LIMIT/MINOR 15 MIN	$50.45		
99242		OFFICE CNSLT NEW/ESTAB LOW SEVERITY 30 MIN	$92.69		
99243		OFFICE CNSLT NEW/ESTAB MODERATE SEVERITY 40 MIN	$123.64		
99244	99245	OFFICE CNSLT NEW/ESTAB MOD-HIGH SEVERITY 60 MIN (approp of use determined by Grantee's Medical Advisory Board)	$175.63		
00400	00940	ANESTHESIA FOR BREAST BIOPSY, CONE, LEEP	$49.86	+$16.62 for each 15 minutes (up to $166.20)	
99070		Supplies over and above those usually included with the office visit or other services rendered (trays, supplies or materials provided)	Not to exceed $100.00		

-Bolded procedures require pre-authorization from the WHC state office contact Jeanie @(208)334-5971

*Allowable CPT codes are procedures that can be paid by UGP, but they are paid at the primary CPT medicaid rate.

Forms

FORMS AND INSTRUCTIONS

All clients must complete and sign the enrollment form each year. Staff at the enrollment site must ask questions relating to income and insurance. Signed applications should be FAXED to the Local Coordinating Contractor (LCC) that day, and original mailed to the LCC within the business week to ensure reimbursement for services. All clients must complete and initial the Intake Assessment form.

REQUIRED ENROLLMENT FORMS:

- Idaho *WHC* Enrollment Form (English and Spanish)

  Required annually – Must be submitted to LCC, who then forwards to state WHC office

- Intake Assessment Form (English/Spanish)

  Required at time of enrollment; initialed copy maintained in local contractor client file, copy of WHC services and responsibilities provided to client upon enrollment in WHC

- Limited Enrollment Approval Form

  Required at initial enrollment and must be submitted to LCC, who then forwards copy to state WHC office for:

  - Uninsured women age 40 – 49 at high risk and/or symptomatic for breast cancer,
  - Uninsured women age 30 – 39 symptomatic for breast cancer and/or
  - Uninsured women age 30 – 39 at high risk and/or symptomatic for cervical cancer

- HIPAA – Notice of Privacy Practices (English and Spanish)

  Required at time of enrollment, client keeps

FORMS USED IN DATA ENTRY:

CDC requires all data that is entered and contained in the *WHC* Real Time system. The following paper forms may be used to efficiently collect specific and accurate data from health care professionals, then the LCC shall enter this data in the *WHC* Real Time system.

- Idaho *WHC* Screening Form

  Records results of screening exams and tests

- Idaho *WHC* Abnormal Breast Screening Follow-Up Form #1

  Records results of Diagnostic Mammogram, Ultrasound, Final Diagnosis and Recommendations based on those procedures

- Idaho *WHC* Abnormal Breast Screening Follow-Up Form #2

  Records results of Biopsy, Fine Needle Aspiration, Final Diagnosis and Recommendations based on those procedures

- Idaho *WHC* Abnormal Breast Screening Follow-Up Form #3

Records results of Surgical Consultation, or Repeat CBE by breast specialist, Final Diagnosis and Recommendations based on those exams

- Idaho *WHC* Abnormal Cervical Screening Follow-Up Form #1

  Records results of Colposcopy with or without biopsy, Final Diagnosis and Recommendations based on those procedures

- Idaho *WHC* Abnormal Cervical Screening Follow-Up Form #2

  Records results of Gynecological Consultation, Other diagnostic procedures (such as LEEP), Final Diagnosis and Recommendations based on those procedures

REQUIRED BCC/MEDICAID FORMS

- Presumptive Eligibility Form Idaho – Medicaid (English and Spanish)

  Fax to state WHC office as soon as client is diagnosed through WHC with breast or cervical cancer and may be eligible for Medicaid

- Idaho Department of Health and Welfare, Breast and Cervical Cancer Medicaid Verification

  Fax to state WHC office for Creditable Insurance Determination as soon as diagnosis is made of breast or cervical cancer through WHC and applying for Medicaid

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@idhw.state.id.us.

- You may request a copy of this notice at any time. Copies of this notice are available at the Department of Health and Welfare offices. This notice is also available on the Department of Health and Welfare's website @ http://www2.state.id.us/dhw/index.htm.

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.
We are required to:

- use and disclose confidential information as required by law;
- maintain the privacy of your information;
- give you this notice of our legal duties and privacy practices for your information; and
- follow the terms of the notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. Right to Review and Copy

You have the right to ask to review and copy your information as allowed by law.

If you would like to ask to review and copy your information, a "Records Request" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 3 working days of receipt of your request. The Department may extend the response time to 7 additional working days if the information you have requested cannot be located or retrieved within the original 3 days. You will be sent a notification of an extension and the reason for the extension.

If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from our files, the fee will be 10¢ per page.

You will be told if there is information we are legally prevented from disclosing to you.

2. Right to Amend

You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. Right to Restrict Health Information Disclosures

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction.

4. Right to an Alternate Means of Delivery

You have the right to ask that we deliver your information to you at different mailing address. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. Right to a Report of Health Information Disclosures

You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment**. We may use your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care, such as family members, informal or legal representatives, or others that give you services as part of your care.

- **For Payment**. We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

- **For Business Operations**. We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For Appointment Reminders
- For Treatment Alternatives
- As Required by Law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- To Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threat to Health or Safety
- To Military and Veterans organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

CHANGES TO THIS NOTICE

The Department has the right to change this notice. A copy of this notice is posted at our Department offices. The effective date of this notice is shown in the top right-hand corner of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the notice that is currently in effect.

COMPLAINTS

If you believe your health information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices. To file a complaint with the Department, send your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U.S Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.

Costs associated with this publication are available from the Idaho Department of Health and Welfare, IDHW/50,000-6/03. Cost per unit $.03

IDAHO DEPARTMENT OF HEALTH & WELFARE

Aviso sobre las Prácticas de Privacidad

ESTE AVISO DESCRIBE CÓMO SU INFORMACIÓN PUEDE SER USADA Y DIVULGADA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. POR FAVOR REVÍSELA CON CUIDADO.

- Si usted tiene cualquier pregunta sobre este Aviso, por favor contacte a la Oficina de Privacidad del Departamento de Salud y Bienestar al 208-334-6519 ó por correo electrónico al PrivacyOffice@idhw.state.id.us.

- Usted puede solicitar una copia de este aviso en cualquier momento. Copias de este aviso están disponibles en las oficinas del Departamento de Salud y Bienestar. Este aviso también está disponible en el sitio web del Departamento de Salud y Bienestar en http://www2.state.id.us/dhw/index.htm.

EL PROPÓSITO DE ESTE AVISO

Este Aviso sobre las Prácticas de Privacidad describe cómo el Departamento de Salud y Bienestar de Idaho (Departamento) maneja información confidencial, siguiendo los requisitos estatales y federales. Todos los programas dentro del Departamento pueden compartir información confidencial entre sí como sea necesario para proveerle beneficios o servicios y para el propósito normal de un negocio. El Departamento también puede compartir su información confidencial con otros fuera del Departamento como sea necesario para proveerle beneficios o servicios.

Nosotros estamos dedicados a proteger su información confidencial. Nosotros creamos archivos de los beneficios o servicios que usted recibe por parte del Departamento. Nosotros necesitamos estos archivos para proveerle cuidado y servicios de calidad. También necesitamos estos documentos para seguir las leyes locales, estatales y federales.
Se nos requiere de:

- usar y divulgar información confidencial como la ley lo requiere;
- mantener privada su información;
- darle este aviso de nuestros deberes legales y prácticas de privacidad para su información; y
- seguir los términos del aviso que está actualmente en efecto.

Este Aviso sobre las Prácticas de Privacidad no afecta su elegibilidad para recibir beneficios o servicios.

SUS DERECHOS SOBRE SU INFORMACIÓN CONFIDENCIAL

1. Derecho de Revisar y Copiar

Usted tiene el derecho de revisar y copiar su información como lo permita la ley.

Si a usted le gustaría revisar y copiar su información, el formulario "Records Request" (Solicitud de Documentos) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento le responderá dentro de 3 días de trabajo de cuando se recibió su petición. El Departamento puede extender el tiempo que se toma en responderle a 7 días de trabajo adicionales si la información que solicita no puede ser localizada ni recuperada dentro de los 3 días originales. Si este es el caso se le enviará un aviso de la extensión y la razón de ésta.

Si desea recibir una copia de la información, puede que exista un cobro. Si pide 100 páginas o más de nuestros archivos, el cobro puede ser de 10¢ por página.

Se le notificará si existe información que legalmente no le podemos divulgar.

2. Derecho de Corregir

Usted tiene el derecho de pedirnos que hagamos cambios a su información si cree que la información que tenemos sobre usted es errónea o no está completa.

Si le quiere pedir al Departamento que cambie su información, el formulario "Request to Amend Records" (Solicitud para Corregir Documentos) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento le responderá a su petición dentro de 10 días.

Nosotros podemos negar su petición si nos pide que cambiemos información que:

- No fue creada por el Departamento;
- No es parte de la información que es mantenida por el Departamento ni es para éste;
- No es parte de la información que se le permite revisar y copiar; o
- Nosotros determinamos que está correcta y completa.

3. Derecho de Restringir Divulgaciones de la Información sobre la Salud

Usted tiene el derecho de pedirnos que no compartamos su información sobre la salud para su tratamiento o servicios, o en el propósito normal de un negocio. Usted nos debe decir qué información no desea que compartamos y con quién no la debemos compartir.

Si usted quiere pedirle al Departamento que no comparta su información, el formulario "Request to Restrict Health Information Disclosures" (Solicitud para Restringir las Divulgaciones de la Información sobre la Salud) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento responderá a su petición dentro de 10 días.

Si otorgamos su petición, nosotros cumpliremos con su deseo a menos que la información se necesite para darle tratamiento en caso de emergencia o hasta que suspenda la restricción.

4. Derecho a una Manera Alterna de la Entrega de Información

Usted tiene el derecho de pedir que le entreguemos su información a una dirección diferente. Por ejemplo, nos puede pedir que le enviemos su información de un programa a una dirección diferente de la de otros programas de los cuales usted recibe servicios o beneficios.

Si usted desea solicitar una manera alterna de la entrega de su información, el formulario "Request for Alternate Means of Delivery" (Solicitud para una Manera Alterna de Entrega) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento responderá a su petición dentro de 10 días.

Nosotros no le preguntaremos la razón de su petición. Todas las solicitudes razonables serán aprobadas.

5. Derecho a un Reporte de las Divulgaciones de la Información sobre la Salud

Usted tiene el derecho a un reporte de las divulgaciones de la información sobre su salud. Este reporte de divulgaciones no incluye las veces en que hemos compartido su información de la salud para tratamiento, pago para su tratamiento o para el propósito normal de un negocio, o las veces que nos autorizó para compartir su información.

Si usted desea solicitar un reporte de las divulgaciones de la información sobre su salud, el formulario "Request to Receive a Report of Health Information Disclosures" (Solicitud para Recibir un Reporte de las Divulgaciones de la Información sobre la Salud) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento responderá a su petición dentro de 10 días.

El primer reporte que nos pida y que recibe en el paso de un año será libre de cobro. Para reportes adicionales dentro del mismo año, cobraremos los gastos de proveerlo. Nosotros le diremos el costo y usted puede remover o cambiar su petición en ese entonces antes de que se le cobre algo.

CÓMO EL DEPARTAMENTO PUEDE USAR Y COMPARTIR SU INFORMACIÓN

Ocasiones en donde no se necesita su permiso

- **Para Recibir Tratamiento**. Nosotros podemos usar su información para darle beneficios, tratamiento o servicios. Podemos compartir su información con una enfermera, un profesional médico u otra persona que le está dando tratamiento o servicios. Los programas en el Departamento también pueden compartir su información para coordinar servicios que tal vez necesite. Nosotros también podemos compartir su información con personas fuera del Departamento que participan en su cuidado, tales como miembros de la familia, representantes informales o legales, u otros que le pueden dar servicios como parte de su cuidado.

- **Para Recibir Pago**. Nosotros podemos usar y compartir su información para el tratamiento y los servicios que recibe por medio del Departamento puedan ser pagados. Por ejemplo, necesitamos darle a su compañía de seguro médico información sobre el tratamiento o los servicios que recibió para que su seguro médico pueda pagar el tratamiento o los servicios.

- **Para la Operación del Negocio**. Nosotros podemos usar y compartir su información con propósito de operar el negocio. Esto es necesario para la operación diaria del Departamento y para asegurarnos de que todos nuestros clientes reciben calidad de cuidado. Por ejemplo, podemos usar su información para revisar nuestra provisión de tratamiento y servicios y para evaluar el desempeño de nuestro personal cuando le provee servicios.

Ocasiones en donde se necesita su permiso

- **Por razones que no son para el tratamiento, el Pago o la Operación del Negocio.** Existen ocasiones cuando el Departamento tenga que usar y compartir su información por razones que no son para el tratamiento, el pago y la operación del negocio como se explicó arriba. Por ejemplo, si su empleador o escuela le pide información al Departamento que no es parte del tratamiento, del pago ni la operación del negocio, el Departamento le pedirá una autorización por escrito permitiéndonos compartir esa información. Si nos da permiso para usar y compartir su información, usted también puede suspender ese permiso en cualquier momento, si lo hace por escrito. Si suspende su permiso, no usaremos ni compartiremos esa información. Usted debe comprender que no podemos recuperar información que ya compartimos con su autorización.

- **Personas que son parte de su cuidado o pago por su cuidado.** Nosotros podemos darle información a un miembro de la familia, a un representante legal, o a alguien a quien usted ha designado como parte de su cuidado. También le podemos dar su información a alguien que le ayuda a pagar por su cuidado. Si usted no puede decir sí o no a dicha divulgación, podemos compartir su información como sea necesario si determinamos en nuestra opinión profesional que es para su bienestar. También, podemos compartir su información en un desastre para que su familia o representante legal esté informada sobre su condición, estado y localidad.

Otros usos de su información que pueden ser hechos sin su permiso

- Para recordatorios de citas
- Para alternativas de tratamiento
- Como lo requiera la ley
- Para el riesgo de la salud pública
- Para la policía
- Para demandas y disputas
- Para médicos forenses, examinadores médicos, directores de funerales
- Para donar órganos y tejido
- Para tratamiento de emergencia
- Para prevenir una amenaza grave a la salud y seguridad
- Para organizaciones militares y de veteranos
- Para actividades de supervisión de la salud
- Para actividades de seguridad nacional e inteligencia
- Para instituciones correccionales

REQUISITOS ESPECIALES

Información que se ha recibido de un programa de tratamiento para el abuso de sustancias financiado con fondos federales o por medio del programa de bebés y niños pequeños no será divulgada sin la autorización específica de la persona o de un representante legal.

CAMBIOS A ESTE AVISO

El Departamento tiene el derecho de cambiar este aviso. Una copia de este aviso se encuentra fijado en nuestras oficinas del Departamento. La fecha de vigencia de este aviso se muestra arriba de cada página. Si el Departamento hace algún cambio a este Aviso sobre las Prácticas de Privacidad, el Departamento seguirá los términos del aviso que está actualmente en vigencia.

QUEJAS

Si usted cree que sus derechos de privacidad sobre su información de la salud han sido violados, usted puede someter una queja por escrito con el Departamento de Salud y Bienestar de Idaho. Todas las quejas que son entregadas al Departamento deben ser por escrito en el formulario de "Complaint Privacy" (Quejas de Privacidad) que está disponible en las oficinas del Departamento. Para someter una queja con el Departamento, envíe el formulario completado de Quejas de Privacidad a:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

Si usted cree que sus derechos de privacidad sobre su información de la salud han sido violados, usted también puede someter una queja con el Departamento de Salud y Servicios Humanos de los EE.UU. Su queja debe ser por escrito y debe poner el nombre de la organización la cual es el sujeto de su queja y describir lo que cree que fue violado. Envíe su queja por escrito a:

Region 10
Office for Civil Rights
U. S Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

Para todas las quejas sometidas por correo electrónicas enviar a OCRComplaint@hhs.gov

Una queja ya sea con el Departamento de Salud y Bienestar o con el Secretario de Salud y Servicios Humanos debe ser sometida dentro de 180 días de cuando usted cree que la violación a la privacidad ocurrió. Este límite de tiempo para someter quejas puede ser suspendido con buena causa.

Usted no será castigado ni se tomarán represalias en su contra por someter una queja.

Los costos asociados con esta publicación están disponibles en el Departamento de Salud y Bienestar de Idaho, IDHW/50,000-6/03. Costo por unidad $.03

Enrollment Forms

Idaho Women's Health Check Enrollment Form

IDAHO DEPARTMENT OF HEALTH & WELFARE

vers. (6.08.2005)

Client Name (Last, First, M.I.): _____

Social Security #: __ __ __ – __ __ – __ __ __ __

Date of Birth: (___ / ___ / ____)
Month Day Year

Home mailing address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Work Phone: _____

County of Residence: _____

Is there someone whom we may contact in case we can't reach you?

Name: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Are you of Spanish or Hispanic origin, such as Mexican American, Latin American, Puerto Rican, or Cuban?

☐ No
☐ Yes
☐ Unknown

What race do you consider yourself?

☐ White
☐ Black or African American
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaskan Native
☐ Other
☐ Unknown

Client Eligibility

1. Total household income (gross) before taxes: $_____ annually/ $ _____ monthly
2. Total number living in household: _____
3. Number of children under age 19 living with you: _____
4. Do you have a spouse who is currently living with you? Yes ___ No ___
5. Any insurance which covers services provided by WHC? Yes ___ No ___
6. Medicare? Yes ___ No ___ Part B? Yes ___ No ___
7. Age 50 or over? Yes ___ No ___

Local WHC
Client is eligible based on:
___ income guidelines
___ no insurance for WHC services
___ age 50-64 or meets criteria for under 50
___ authorization for under 50 attached

Verification by: _____
(Initials)

Consent for Release of Information and Statement of Confidentiality

I consent to the gathering, use, and disclosure of my information by the Idaho Department of Health and Welfare Women's Health Check (WHC) Program. This information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services and to conduct normal business operations. By agreeing to take part in WHC, I give permission to any and all of my health care providers, clinics and/or hospitals to provide all information concerning Pap smears, breast exams and mammograms, and any related care to the WHC Program.

Information given to Women's Health Check will be confidential, which means information will be used to meet the purpose of the WHC Program and any published reports will not identify me by name. I understand that notifying me of test results is a very important purpose of the Program, and that all available resources may be used to notify me if I have an abnormal test result.

I agree to have a mammogram, breast exam, and Pap test yearly or as recommended and any diagnostic tests (program funded) determined necessary. I give my consent for the local WHC and the Idaho Medicaid program to coordinate my care and provide case management services as needed.

I understand that knowingly providing false information may result in criminal, civil, or administrative action.

I, _____ , swear that the information given on this form is true and correct.
(Print your name here)

Signature: _____ Date Signed: (___ / ___ / ____)
Month Day Year

I understand that my participation in this Program is voluntary and that I may drop out and withdraw my consent to release information at any time.
I have received a copy of the Department of Health and Welfare's Notice of Privacy Practice.

Enrollment Site: _____

Local Coordinating Contractor: _____

Date of Enrollment into Women's Health Check: (___ / ___ / ____)
Month Day Year

☐ New WHC Client
☐ Returning WHC Client

How did this client find out about Women's Health Check services?

☐ Provider ☐ WHC Reminder ☐ Television ☐ Newspaper ☐ Radio ☐ Friend/Family
☐ Poster/Brochure at _____ (specify location) ☐ Other (please specify): _____

Idaho Chequeo de la Salud para Mujeres
Forma de Inscripción

IDAHO DEPARTMENT OF HEALTH & WELFARE

vers. (6.08.2005)

Nombre de la cliente: _____
(Apellido, Primer y Segundo Nombre)

Seguro Social #: __ __ __–__ __ __–__ __ __ __

Fecha de Nacimiento: (___/___/____)
Mes Dia Año

Dirección de la casa: _____

Ciudad: _____ Estado: _____ Código Postal: _____

Teléfono (casa): _____ Teléfono (trabajo): _____

Condado de residencia: _____

¿Hay alguien a quien podamos contactar en caso de que no lo podamos localizar?

Nombre: _____ Teléfono: _____

Dirección Postal: _____

Ciudad: _____ Estado: _____ Código Postal: _____

¿Usted es de origen Hispano, como Mexicano-Americano, Latino Americano, Portorriqueño, Cubano?

☐ No
☐ Si
☐ Desconocido

¿De qué raza se considera usted?

☐ Caucásica
☐ Negra o African-Americano
☐ Asiática
☐ Hawaiian Indigena o Otro Islas Pacificas
☐ Indian Indigena de U.S. o Alaskan Indigena
☐ Otro
☐ Desconocido

Elegibilidad de la Cliente

1. Ingresos de casa antes de impuestos: $_____ anualmente/ $ _____ mensual
2. ¿Cuantas personas en total viven en casa? _____
3. ¿Cuantas personas menores de 19 viven en casa? _____
4. ¿Tiene esposo que vive con usted ahora? Si ___ No ___
5. ¿Tiene aseguranza que cubre servicios del chequeo de mujeres? Si ___ No ___
6. ¿Tiene Medicare? Si ___ No ___ ¿Tiene parte B? Si ___ No ___
7. ¿Sobre la edad de 50? Si ___ No ___

Local WHC
Client is eligible based on:
___ income guidelines
___ no insurance for WHC services
___ age 50-64 or meets criteria for under 50
___ authorization for under 50 attached

Verification by: _____
(Initials)

Consentimiento Para Dar Información

Yo doy mi consentimiento para que el Departamento de Salud y Bienestar de Idaho obtenga, use y divulgue información sobre mí. Esta información es necesaria para proveer beneficios o servicios, para obtener pago por mis beneficios o servicios y para llevar a cabo las operaciones normales de la agencia. Al tomar parte en el WHC, yo doy permiso a los proveedores del cuidado de la salud, a las clínicas y/u hospitales de proveer toda información con respecto a los exámenes del Papanicolau, del seno y los mamogramas y cualquier cuidado relacionado al Programa.

La información dada al WHC será confidencial, lo que significa que la información será usada para llenar el propósito del Programa del WHC y cualquier reporte publicado no me identificará por nombre. Yo entiendo que el avisarme de los resultados de un examen es muy importante para el programa, y que todos los recursos disponibles pueden ser usados para notificarme si tengo un resultado anormal en un examen.

Yo acuerdo tener un mamograma, un examen del seno y un Papanicolau cada año o como lo recomienden y cualquier examen de diagnóstico (financiado por el programa) si es necesario. Yo doy mi consentimiento para que el WHC local y el programa de Medicaid de Idaho dirigan mi caso tal como sea necesario.

Yo entiendo que proveer información falsa a sabiendas puede resultar en una acción criminal, civil o administrativa.

Yo, _____, juro que la información dada en este formulario es verdadera y correcta.
(imprimir su nombre por favor)

Firma: _____ Fecha de la firma: (___/___/____)
Mes Dia Año

Yo entiendo que mi participación en este programa es voluntaria y que puedo salirme y quitar mi consentimiento de liberar información a cualquier tiempo. He recibo una copia de la notificación del Departmento de Salud y Bienestar sobre la practica de Privacidad.

Enrollment Site: _____

Local Coordinating Contractor: _____

Date of Enrollment into Women's Health Check: (___/___/____)
Month Day Year

☐ New WHC Client
☐ Returning WHC Client

How did this client find out about Women's Health Check services?

☐ Provider ☐ WHC Reminder ☐ Television ☐ Newspaper ☐ Radio ☐ Friend/Family
☐ Poster/Brochure at _____ (specify location) ☐ Other (please specify): _____

Intake Assessment

vers. (03.9.2006)

Name/Nombre: _____ _____ _____ **Date/Fecha:** (____/____/_____)
Last (Print)/Apellido (Letra de molde) First/Primer Nombre MI/Inicial del Medio Nombre Month Mes Day Día Year Año

Services Covered

- **Clinical Breast Exam/Mammogram** - Yearly
- **Pap Test** - Yearly or as recommended by your health care provider
- **Diagnostic Tests** - if needed
- **Treatment** - if needed and you meet eligibility requirements

Tests not related to breast or cervical cancer screening or not authorized by Women's Health Check will not be covered.

Your Responsibility

- Having a mammogram, clinical breast exam, and Pap test yearly or as recommended
- Having additional diagnostic tests if any abnormalities are found
- Keeping appointments for screening and follow-up services.

A health provider may ask for diagnostic tests that are not covered by Women's Health Check. Please check with your health care provider to make other arrangements for the tests or services not covered by this program.

☛ **Client Initial** _____

Is there anything that might prevent you from keeping your appointments?

☐ Transportation/Travel distance/Work schedule
☐ Lack of money/Child or family care
☐ Need more information/Questions about screening
☐ Other: (translation/making appointments)

Appointment Preferences: ☐ *a.m.* ☐ *p.m.*
☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Scheduled Appointments:

☐ Pap _____ date
☐ Clinical Breast Exam _____ date
☐ Mammogram _____ date

Servicios Incluidós

- **Examen Clínico del Seno/Mamografia** - Anual
- **Examen del Papanicolau** - Anual o según lo recomiende su proveedor del cuidado de la salud
- **Pruebas de Diagnóstico** - según se necesiten
- **Tratamiento** - según se necesite y si llena los requisitos de elegibilidad

Las pruebas que no están relacionadas a las evaluaciones para el cáncer del seno o al cáncer cervical o que no han sido autorizadas por Chequeo de la Salud para Mujeres (Women's Health Check) no serán cubiertas.

Responsabilidad de la Cliente

- Hacerse un mamografia, un examen clínico del seno, y una prueba del Papanicolau anual o según se recomiende
- Hacerse pruebas adicionales de diagnóstico si se encuentran anormalidades
- Mantener las citas para los servicios de chequeo y de reevaluación

De vez en cuando un proveedor del cuidado de la salud pide pruebas de diagnóstico que no son cubiertas por el Chequeo de la Salud para Mujeres (Women's Health Check). Por favor averigüe con su proveedor del cuidado de la salud para hacer otros arreglos sobre las pruebas o servicios que no cubre el programa.

☛ **Iniciales de la Cliente** _____

¿Hay algo que le prevenga de asistir a sus citas?

☐ Transportación/Distancia del viaje/Horario de trabajo
☐ Falta de dinero/Cuidado de niños o de familia
☐ Necesita más información/Preguntas sobre los procesos de evaluación
☐ Otro: Necesito ayuda haciendo citas/Interpretación (idioma)

Preferencias Citas: ☐ *a.m.* ☐ *p.m.*
☐ Lunes ☐ Martes ☐ Miércoles ☐ Jueves ☐ Viernes

Citas Fijadas: ☐ Papanicolau _____ fecha
☐ Examen Clínico del Seno _____ fecha
☐ Mamografia _____ fecha

☛ **Take your *Women's Health Check* Identification Card to your appointment.**
Esté segura de llevar con usted a la cita su tarjeta de identificación del *Chequeo de la Salud para Mujeres.* ☚

If at any time you do not wish to participate in Women's Health Check, you may cancel your enrollment by contacting your local Women's Health Check office and letting us know.
Si en cualquier momento no desea participor en el programa del Chequeo de la Salud para Mujeres (Women's Health Check), llame a nuestra oficina para cancelar su inscripción.

Women's Health Check
Services and Responsibilities

vers. (03.2006)

Client Copy

Services Covered

- **Clinical Breast Exam / Mammogram** - Yearly
- **Pap Test** - Yearly or as recommended by your health care provider
- **Diagnostic Tests** - if needed
- **Treatment** - if needed and you meet eligibility requirements

Tests not related to breast or cervical cancer screening or not authorized by Women's Health Check will not be covered.

Your Responsibility

- Having a mammogram, clinical breast exam, and Pap test yearly or as recommended
- Having additional diagnostic tests if any abnormalities are found
- Keeping appointments for screening and follow-up services.

A health provider may ask for diagnostic tests that are not covered by Women's Health Check. Please check with your health care provider to make other arrangements for the tests or services not covered by this program.

Scheduled Appointments:

☐ Pap _____
date

☐ Clinical Breast Exam _____
date

☐ Mammogram _____
date

Servicios Incluidós

- **Examen Clínico del Seno/Mamografia** - Anual
- **Examen del Papanicolau** - Anual o según lo recomiende su proveedor del cuidado de la salud
- **Pruebas de Diagnóstico** - según se necesiten
- **Tratamiento** - según se necesite y si llena los requisitos de elegibilidad

Las pruebas que no están relacionadas a las evaluaciones para el cáncer del seno o al cáncer cervical o que no han sido autorizadas por Chequeo de la Salud para Mujeres (Women's Health Check) no serán cubiertas.

Responsabilidad de la Cliente

- Hacerse un mamografia, un examen clínico del seno, y una prueba del Papanicolau anual o según se recomiende
- Hacerse pruebas adicionales de diagnóstico si se encuentran anormalidades
- Mantener las citas para los servicios de chequeo y de reevaluación

De vez en cuando un proveedor del cuidado de la salud pide pruebas de diagnóstico que no son cubiertas por el Chequeo de la Salud para Mujeres (Women's Health Check). Por favor averigüe con su proveedor del cuidado de la salud para hacer otros arreglos sobre las pruebas o servicios que no cubre el programa.

Citas Fijadas:

☐ Papanicolau _____
fecha

☐ Examen Clínico del Seno _____
fecha

☐ Mamografia _____
fecha

Take your *Women's Health Check* Identification Card to your appointment.
Esté segura de llevar con usted a la cita su tarjeta de identificación del *Chequeo de la Salud para Mujeres.*

If at any time you do not wish to participate in Women's Health Check, you may cancel your enrollment by contacting your local Women's Health Check office and letting us know.
Si en cualquier momento no desea participor en el programa del Chequeo de la Salud para Mujeres (Women's Health Check), llame a nuestra oficina para cancelar su inscripción.

Limited Enrollment Approval

- **Uninsured women age 40 – 49 at high risk and/or symptomatic for breast cancer**
  Uninsured women age 30-39 symptomatic for breast cancer
- **Uninsured women age 30 - 39 at high risk and/or symptomatic for cervical cancer**

Client Name: _____ **Age:** _____ **D.O.B.** _____

Enrollment based the following risk factors or symptoms of breast cancer:

Clinical Findings:
(Uninsured women **age 30-49** can be enrolled if symptomatic)

❒ **unilateral** ❒ **irregular boundaries**

❒ **non-moveable** ❒ **tender** ❒ **non-tender**

❒ **Discharge** ❒ **Scaling**

❒ **Dimpling or retraction** ❒ **Other**_____

❒ **Confirmed by CBE, performed by**_____

❒ **Confirmed by mammogram**

Risk Factors:
(Uninsured women **age 40 – 49** can be enrolled if the following applies)

❒ **Breast cancer hx: Self** _____ **Age at onset:**____

❒ **Breast biopsy hx : Number of biopsies:** ____

❒ **Result of atypical hyperplasia**

❒ **Previous chest irradiation**

Additional Information: ❒ **Post menopausal**

_____
_____
_____
_____
_____
_____
_____

Enrollment based the following risk factors or symptoms of cervical cancer:
(Uninsured women **age 30 – 39** can be enrolled based on having at least one risk factor and/or symptoms for cervical cancer)

Risk Factors:

❒ **Never or rarely screened:**
(Defined by Centers for Disease Control as a risk factor)

❒ **Has never had a Pap smear**

❒ **5 years or more since last Pap smear**

❒ **Hx of reproductive cancer**

Clinical Findings:

❒ **Previous abnormal pap/cervical cytology/colposcopy/or biopsy**

Date of prior cytology and results if known

_____

Date of colposcopy/ biopsy and results if known

_____

❒ **HPV Positive Date** _____

❒ **Hx of other sexually transmitted infections**

❒ **Abnormal bleeding** ❒ **Lesion – size** _____

❒ **Prior LEEP/Cone** ❒ **Cervical Erosion**

Additional Clinical information (i.e. pertinent clinical history, physical findings, gynecological surgery

❒ **Tobacco use: Number of years** _____

_____
_____
_____
_____
_____

Based on information documented above, this client is at high risk and/or symptomatic for breast and/or cervical cancer. Client is not currently undergoing diagnostic workup. Enrollment in Women's Health Check for breast and/or cervical cancer screening is recommended.

Clinician: _____ **Title:** _____ **Phone:** _____ **Date:** _____

Contacting Clinic: _____

Submit with Enrollment Form

Idaho WHC Screening Form

Client Name (Last, First, M.I.): _____ Screening Location/City _____

Date of Birth: (___ / ___ / ____) Referral Source: _____

Ever had a mammogram?
- ☐ No
- ☐ Yes
- ☐ Unknown

Date of previous mammogram?: (___ / ____) Month Year

Breast Symptoms?
- ☐ No
- ☐ Yes
  - ☐ Lump
  - ☐ Discharge
  - ☐ Tenderness
  - ☐ Other
  - ☐ Unknown

Breast Implants? ☐ No ☐ Yes

History of Breast Cancer? ☐ No

☐ Self: if yes, when? (___ / ____) Month Year

☐ Family If yes, please indicate age and relationship of family member(s): _____

Date of Clinical Breast Exam: (___ / ___ / ____) Month Day Year

CBE funded by WHC? ☐ No ☐ Yes

Clinical Breast Exam Results (check only one):

- ☐ Benign Finding (Not suspicious: ☐ Fibrocycstic Changes ☐ Nodularity)
- ☐ Discrete Palp Mass (Dx Benign)
- ☐ Normal Exam (WNL)
- ☐ Not Needed/Normal CBE w/in previous 2 months
- ☐ Not needed—other or unknown reason
- ☐ Refused
- ☐ Bloody/Serous nipple discharge*
- ☐ Discrete palp mass - Susp for CA*
- ☐ Nipple or Areolar scaliness*
- ☐ Skin dimpling or retraction*

} Suspicious, requires follow-up*

Clinician: _____

Mammogram

Date of: (___ / ___ / ____) Month Day Year Performed: (___ / ___ / ____) Month Day Year

Location of mammography screening: _____

If no mammogram performed, please indicate reason under **Mammogram Results**.

Was mammogram funded by WHC? ☐ No ☐ Yes

Mammogram Results (check only one):

- ☐ Negative
- ☐ Benign finding
- ☐ Probably benign—short term follow-up suggested
- ☐ Suspicious abnormality—consider biopsy*
- ☐ Highly suggestive of malignancy*
- ☐ Assessment is incomplete (additional imaging study needed)*
- ☐ Unsatisfactory*
- ☐ Not needed (normal mammogram w/in previous 12 months)
- ☐ Needed but not performed at this visit
- ☐ Result pending
- ☐ Refused

Date client was notified: (___ / ___ / ____) Month Day Year

Diagnostic work-up planned for breast cancer?
- ☐ Not planned
- ☐ Yes, based on
  - ☐ Abnormal CBE
  - ☐ Abnormal mammogram
  - ☐ Patients concern

If Yes, what is recommended? _____

Next recommended mammogram date: (___ / ___ / ____) Month Day Year

*all screening results which fall into a gray box require diagnostic follow-up

Ever had a Pap smear?
- ☐ No
- ☐ Yes Date of previous Pap smear?: (___ / ____) Month Year
- ☐ Unknown

Ever had a Hysterectomy?
- ☐ No
- ☐ Yes
- ☐ Unknown
- ☐ Cervical Neoplasia or Cervical Cancer
- ☐ Other: _____

Normal Paps through WHC:
Date: (___ / ____) Month Year
Date: (___ / ____) Month Year
Date: (___ / ____) Month Year

Pelvic Exam: (___ / ___ / ____) Month Day Year **Pelvic funded by WHC?** ☐ No ☐ Yes

Pelvic Exam Results (check only one):

- ☐ Normal
- ☐ Not done, normal pelvic exam w/in last 12 months
- ☐ Not done - oth/unk reason
- ☐ Not indicated/Not needed
- ☐ Refused
- ☐ Abnormal, suspicious of cancer (cervical neoplasia)
- ☐ Abnormal, not suspicious of cervical cancer

Cervix/Partial cervix present? ☐ No ☐ Yes

Clinician: _____

Pap smear performed?

☐ No—please indicate reason under Pap Smear Results

☐ Yes **Date Performed:** (___ / ___ / ____) Month Day Year

Specimen Adequacy: ☐ Satisfactory ☐ Unsatisfactory

Specimen Type:
- ☐ Conventional Smear ☐ Other: _____
- ☐ Liquid Based

Lab: _____

Pap Smear Results (check only one):

- ☐ Low-grade SIL: HPV, Mild Dysplasia/CIN I
- ☐ Needed but not performed at this visit
- ☐ Negative for Intraepithelial Lesion or Malignancy/(infect./inflam./reactive)
- ☐ Not done - oth/unk reason
- ☐ Not needed (normal Pap w/in last 12 months/hysterectomy)
- ☐ Other
- ☐ Refused
- ☐ Result pending
- ☐ Adenocarcinoma (Endocervical, Endometrial, Extrauterine), NOS*
- ☐ Atypical glandular cells of undetermined significance (**AGUS**)
- ☐ Atypical Squamous Cells-Cannot exclude High Grade SIL (**ASC-H**)*
- ☐ High-grade SIL: Moderate and Severe Dysplasia, CIS/CIN2 and CIN3*
- ☐ Atypical Squamous Cells-Undetermined Significance (**ASC-US**)
- ☐ Squamous Cell Carcinoma

Date client was notified: (___ / ___ / ____) Month Day Year

Diagnostic work-up planned for cervical cancer?
- ☐ Not planned
- ☐ Yes, based on
  - ☐ Abnormal pelvic exam
  - ☐ Abnormal Pap smear
  - ☐ Patients concern

If Yes, what is recommended? _____

Was Pap smear funded by WHC? ☐ No ☐ Yes

Next recommended Pap smear date: (___ / ___ / ____) Month Day Year

vers. (5.2006)

Sample

Women's Health Check Waiting List
_____(LCC)

Women's Health Check is a breast and cervical cancer screening program, funded through CDC to screen priority populations:

- **Low income, with no other resource for payment, such as insurance**
- **Women age 50-64 (screening mammogram, clinical breast exam)**
- **Women age 40-64 (Pap test, pelvic exam)**
- **Enrollment for women age 30+ presenting with symptoms or high risk limited to 25% of total new enrollment**
- **Must enroll screening priority prior to other referrals**

Priority Age Screening Waiting List

Date	Age	Contact #	Breast and/or Cervical	Comments	Date Enrolled
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					

Waiting List for Women with Symptoms < Priority Age

Date	Age	Contact #	Service Needed	Comments	Date Enrolled

SAMPLE

Women's Health Check Waiting List
_____(Site and LCC)

Women's Health Check is a breast and cervical cancer screening program, funded through CDC to screen priority populations:

- **Low income with no other resource for health care reimbursement (such as insurance)**
- **Women age 50-64 (screening mammogram, CBE)**
- **Women age 40-64 (Pap test, pelvic exam)**
- Enrollment for uninsured women age 30+ presenting with symptoms limited to 25% of total new enrollment
- Must enroll screening priority prior to other referrals

Priority Age Screening Waiting List

Date	Age	Name and Contact #	Breast &/or Cervical	Comments	Date Enrolled
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					

Waiting List for Women with Symptoms < Priority Age

Date	Age	Name and Contact #	Service Needed	Comments	Date Enrolled

Screening
and Diagnosis Forms

Idaho WHC Abnormal Breast Screening Follow-up Form #1

Form AB-1 vers. (2.25.2003)

Women's Health Check Idaho

Client I.D. #: _____
Client Name (Last, First, M.I.): _____
Social Security #: __ __ __—__ __ —__ __ __ __

Diagnostic Mammogram (76090, 76091)

Location: _____

Date Scheduled: (___ / ___ / ____)
Month Day Year

Date Performed: (___ / ___ / ____)
Month Day Year

Date Results Received: (___ / ___ / ____)
Month Day Year

Results (circle ONE)
(Birads)

- ☐ 0 Assessment Incomplete
- ☐ 1 Negative
- ☐ 2 Benign
- ☐ 3 Probably Benign
- ☐ 4 Suspicious Abnormality (consider biopsy)
- ☐ 5 Highly Suggestive of Malignancy
- ☐ Needed but not performed
- ☐ Refused
- ☐ Unsatisfactory

Ultrasound (76645)

Location: _____

Date Scheduled: (___ / ___ / ____)
Month Day Year

Date Performed: (___ / ___ / ____)
Month Day Year

Date Results Received: (___ / ___ / ____)
Month Day Year

Results (circle ONE)

- ☐ Refused
- ☐ Normal/No abnormality noted
- ☐ Cystic mass
- ☐ Suspicious for malignancy
- ☐ Other benign abnormality
- ☐ Unknown

Final Diagnosis

- ☐ Carcinoma *in situ* - Other
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer

Stage at diagnosis (AJCC classification, 1988)

AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Breast Cancer Not Diagnosed
- ☐ Not yet determined (requires additional diagnostic procedures)

Final Diagnosis

- ☐ Carcinoma *in situ* - Other
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer

Stage at diagnosis (AJCC classification, 1988)

AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Breast Cancer Not Diagnosed
- ☐ Not yet determined (requires additional diagnostic procedures)

Client Notified of Results: (___ / ___ / ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow Routine Screening
- ☐ Short-term Follow-up mammogram — (months:_____)
- ☐ Additional mammographic views (diagnostic mammogram)
- ☐ Repeat Mammogram Immediately
- ☐ CBE by consultation
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Obtain Definitive Treatment

Client Notified of Results: (___ / ___ / ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow Routine Screening
- ☐ Short-term Follow-up mammogram — (months:_____)
- ☐ Additional mammographic views (diagnostic mammogram)
- ☐ Repeat Mammogram Immediately
- ☐ CBE by consultation
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Obtain Definitive Treatment

Final Diagnosis and Treatment Information

Status of Final Diagnosis

(to be completed after final diagnosis has been determined)

- ☐ Work-up pending
- ☐ Work-up complete (___ / ___ / ____) Month Day Year

- ☐ Lost to follow-up
- ☐ Work-up refused (___ / ___ / ____) Month Day Year

Status of Treatment

(to be completed if cancer is diagnosed)

- ☐ Treatment pending
- ☐ Treatment started (___ / ___ / ____) Month Day Year

- ☐ Lost to follow-up
- ☐ Treatment not needed (___ / ___ / ____) Month Day Year

Idaho WHC Abnormal Breast Screening Follow-up Form #2

Form AB-2 vers. (2.25.2003)

Women's Health Check Idaho

Client I.D. #: _____
Client Name (Last, First, M.I.): _____
Social Security #: __ __ __—__ __ —__ __ __ __

Biopsy (19100, 19101)

Location: _____

Date Scheduled: (___ / ___ / ____)
Month Day Year

Date Performed: (___ / ___ / ____)
Month Day Year

Date Results Received: (___ / ___ / ____)
Month Day Year

Results (circle ONE)

- ☐ Refused
- ☐ Hyperplasia
- ☐ Other benign changes
- ☐ Normal breast tissue
- ☐ Carcinoma *in situ* (other/unspecified)
- ☐ Ductal carcinoma *in situ*
- ☐ Lobular carcinoma *in situ*
- ☐ Invasive breast cancer

Fine Needle Aspiration—FNA (88170)

Location: _____

Date Scheduled: (___ / ___ / ____)
Month Day Year

Date Performed: (___ / ___ / ____)
Month Day Year

Date Results Received: (___ / ___ / ____)
Month Day Year

Results (circle ONE)

- ☐ Refused
- ☐ No fluid/tissue obtained
- ☐ Non-suspicious for malignancy
- ☐ Suspicious for malignancy
- ☐ Unknown

Final Diagnosis

- ☐ Carcinoma *in situ* - Other
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer

Stage at diagnosis (AJCC classification, 1988)

AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Breast Cancer Not Diagnosed
- ☐ Not yet determined (requires additional diagnostic procedures)

Client Notified of Results: (___ / ___ / ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow Routine Screening
- ☐ Short-term Follow-up mammogram — (months:_____)
- ☐ Additional mammographic views (diagnostic mammogram)
- ☐ Repeat Mammogram Immediately
- ☐ CBE by consultation
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Obtain Definitive Treatment

Final Diagnosis

- ☐ Carcinoma *in situ* - Other
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer

Stage at diagnosis (AJCC classification, 1988)

AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Breast Cancer Not Diagnosed
- ☐ Not yet determined (requires additional diagnostic procedures)

Client Notified of Results: (___ / ___ / ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow Routine Screening
- ☐ Short-term Follow-up mammogram — (months:_____)
- ☐ Additional mammographic views (diagnostic mammogram)
- ☐ Repeat Mammogram Immediately
- ☐ CBE by consultation
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Obtain Definitive Treatment

Final Diagnosis and Treatment Information

Status of Final Diagnosis

(to be completed after final diagnosis has been determined)

- ☐ Work-up pending
- ☐ Work-up complete (___ / ___ / ____) Month Day Year

- ☐ Lost to follow-up
- ☐ Work-up refused (___ / ___ / ____) Month Day Year

Status of Treatment

(to be completed if cancer is diagnosed)

- ☐ Treatment pending
- ☐ Treatment started (___ / ___ / ____) Month Day Year

- ☐ Lost to follow-up
- ☐ Treatment not needed (___ / ___ / ____) Month Day Year

Idaho WHC Abnormal Breast Screening Follow-up Form #3

Form AB-3 vers. (2.25.2003)

Women's Health Check Idaho

Client I.D. #: _____
Client Name (Last, First, M.I.): _____
Social Security #: __ __ __—__ __ —__ __ __ __

Surgical Consultation (99241, 99242, 99243)

Location: _____

Date Scheduled: (___/___/____) Month Day Year

Date Performed: (___/___/____) Month Day Year

Date Results Received: (___/___/____) Month Day Year

Results (circle ONE)

- ☐ Biopsy/FNA recommended
- ☐ No intervention at this time
- ☐ Not done—other/unknown reason
- ☐ Short-term follow-up
- ☐ Refused
- ☐ Unknown

Consultant—Repeat CBE (99241, 99242, 99243)

Location: _____

Date Scheduled: (___/___/____) Month Day Year

Date Performed: (___/___/____) Month Day Year

Date Results Received: (___/___/____) Month Day Year

Results (circle ONE)

- ☐ Normal
- ☐ Benign
- ☐ DPM (suspicious)
- ☐ DPM (benign)
- ☐ Bloody/serous nipple discharge
- ☐ Nipple/areolar scaliness
- ☐ Skin dimpling/retraction
- ☐ Not done—other/unknown
- ☐ Unknown
- ☐ Refused

Final Diagnosis

- ☐ Carcinoma *in situ* - Other
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer

Stage at diagnosis (AJCC classification, 1988)

AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Breast Cancer Not Diagnosed
- ☐ Not yet determined (requires additional diagnostic procedures)

Client Notified of Results: (___/___/____) Month Day Year

Recommendations (circle all that apply)

- ☐ Follow Routine Screening
- ☐ Short-term Follow-up mammogram — (months:_____)
- ☐ Additional mammographic views (diagnostic mammogram)
- ☐ Repeat Mammogram Immediately
- ☐ CBE by consultation
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Obtain Definitive Treatment

Final Diagnosis

- ☐ Carcinoma *in situ* - Other
- ☐ Ductal Carcinoma *in situ*
- ☐ Lobular Carcinoma *in situ*
- ☐ Invasive Breast Cancer

Stage at diagnosis (AJCC classification, 1988)

AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Breast Cancer Not Diagnosed
- ☐ Not yet determined (requires additional diagnostic procedures)

Client Notified of Results: (___/___/____) Month Day Year

Recommendations (circle all that apply)

- ☐ Follow Routine Screening
- ☐ Short-term Follow-up mammogram — (months:_____)
- ☐ Additional mammographic views (diagnostic mammogram)
- ☐ Repeat Mammogram Immediately
- ☐ CBE by consultation
- ☐ Ultrasound
- ☐ Surgical Consultation
- ☐ Fine Needle Aspiration (FNA)
- ☐ Biopsy
- ☐ Obtain Definitive Treatment

Final Diagnosis and Treatment Information

Status of Final Diagnosis

(to be completed after final diagnosis has been determined)

- ☐ Work-up pending
- ☐ Work-up complete (___/___/____) Month Day Year
- ☐ Lost to follow-up
- ☐ Work-up refused (___/___/____) Month Day Year

Status of Treatment

(to be completed if cancer is diagnosed)

- ☐ Treatment pending
- ☐ Treatment started (___/___/____) Month Day Year
- ☐ Lost to follow-up
- ☐ Treatment not needed (___/___/____) Month Day Year

Idaho WHC Abnormal Cervical Screening Follow-up Form #1

Form AC-1 vers. (2.25.2003)

Women's Health Check Idaho

Client I.D. #: _____
Client Name (Last, First, M.I.): _____
Social Security #: __ __ __—__ __ —__ __ __ __

Colposcopy (57452, 57454)

Location: _____

Date Scheduled: (___ / ___ / ____)
Month Day Year

Date Performed: (___ / ___ / ____)
Month Day Year

Date Results Received: (___ / ___ / ____)
Month Day Year

Results (circle ONE)

- ☐ Within Normal Limits (WNL)
- ☐ CIN-I
- ☐ CIN-II
- ☐ CIN-III/CIS (carcinoma in situ)
- ☐ Adenocarcinoma
- ☐ Invasive Carcinoma
- ☐ Other non-malignant abnormality
- ☐ Refused
- ☐ Unknown

Final Diagnosis

- ☐ Normal/Benign reaction/Inflammation
- ☐ HPV/Condylomata/Atypia
- ☐ Low Grade SIL (biospy diagnosed)
- ☐ High Grade SIL (biopsy dx.)
- ☐ CIN I/mild dysplasia (biopsy dx.)
- ☐ CIN II/moderate dysplasia (biopsy dx.)
- ☐ CIN III/severe dysplasia/carcinoma in situ stage 0 (biopsy dx.)
- ☐ Invasive cervical carcinoma (biopsy dx.)

Stage at diagnosis

FIGO/AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Not yet determined (requires additional diagnostic procedures)
- ☐ Other (please circle): cervical polyps adenocarcinoma Other gynecological cancer Other pelvic abnormality

Client Notified of Results: (___ / ___ / ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow routine screening
- ☐ Short-term follow-up
- ☐ Repeat Pap smear immediately
- ☐ Colposcopy
- ☐ Pelvic ultrasound
- ☐ Other biopsy
- ☐ Gynecological consultation
- ☐ Obtain definitive treatment
- ☐ Hysterectomy
- ☐ LEEP/Cone

Colposcopy—without biopsy (57452)

Location: _____

Date Scheduled: (___ / ___ / ____)
Month Day Year

Date Performed: (___ / ___ / ____)
Month Day Year

Date Results Received: (___ / ___ / ____)
Month Day Year

Results (circle ONE)

- ☐ Within Normal Limits (WNL)
- ☐ Inflammation/infection/HPV
- ☐ Other abnormality
- ☐ Unsatisfactory
- ☐ Refused
- ☐ Unknown

Final Diagnosis

- ☐ Normal/Benign reaction/Inflammation
- ☐ HPV/Condylomata/Atypia
- ☐ Low Grade SIL (biopsy diagnosed)
- ☐ High Grade SIL (biopsy dx.)
- ☐ CIN I/mild dysplasia (biopsy dx.)
- ☐ CIN II/moderate dysplasia (biopsy dx.)
- ☐ CIN III/severe dysplasia/carcinoma in situ stage 0 (biopsy dx.)
- ☐ Invasive cervical carcinoma (biopsy dx.)

Stage at diagnosis

FIGO/AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Not yet determined (requires additional diagnostic procedures)
- ☐ Other (please circle): cervical polyps adenocarcinoma Other gynecological cancer Other pelvic abnormality

Client Notified of Results: (___ / ___ / ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow routine screening
- ☐ Short-term follow-up
- ☐ Repeat Pap smear immediately
- ☐ Colposcopy
- ☐ Pelvic ultrasound
- ☐ Other biopsy
- ☐ Gynecological consultation
- ☐ Obtain definitive treatment
- ☐ Hysterectomy
- ☐ LEEP/Cone

Final Diagnosis and Treatment Information

Status of Final Diagnosis

(to be completed after final diagnosis has been determined)

- ☐ Work-up pending
- ☐ Work-up complete (___ / ___ / ____) Month Day Year
- ☐ Lost to follow-up
- ☐ Work-up refused (___ / ___ / ____) Month Day Year

Status of Treatment

(to be completed if cancer is diagnosed)

- ☐ Treatment pending
- ☐ Treatment started (___ / ___ / ____) Month Day Year
- ☐ Lost to follow-up
- ☐ Treatment not needed (___ / ___ / ____) Month Day Year

Idaho WHC Abnormal Cervical Screening Follow-up Form #2

Form AC-2 vers. (2.25.2003)

Client I.D. #: _____
Client Name (Last, First, M.I.): _____
Social Security #: __ __ __—__ __ —__ __ __ __

Gynecological Consultation (99241, 99242, 99243)

Location:

Date Scheduled: (___ /___/ ____)
Month Day Year

Date Performed: (___ /___/ ____)
Month Day Year

Date Results Received: (___ /___/ ____)
Month Day Year

Results (circle ONE)

- ☐ Within Normal Limits (WNL)
- ☐ Inflammation/infection HPV changes
- ☐ Other abnormality
- ☐ Unsatisfactory
- ☐ Refused
- ☐ Unknown

Other diagnostic procedures

i.e. **LEEP*, Hysterectomy*, Endocervical curettage***
(not all procedures are reimbursed by Women's Health Check)

Location: _____

Date Scheduled: (___ /___/ ____)
Month Day Year

Date Performed: (___ /___/ ____)
Month Day Year

Date Results Received: (___ /___/ ____)
Month Day Year

Results:

***These procedures are not reimbursed by WHC**

Final Diagnosis

- ☐ Normal/Benign reaction/Inflammation
- ☐ HPV/Condylomata/Atypia
- ☐ Low Grade SIL (biopsy diagnosed)
- ☐ High Grade SIL (biopsy dx.)
- ☐ CIN I/mild dysplasia (biopsy dx.)
- ☐ CIN II/moderate dysplasia (biopsy dx.)
- ☐ CIN III/severe dysplasia/carcinoma in situ stage 0 (biopsy dx.)
- ☐ Invasive cervical carcinoma (biopsy dx.)

Stage at diagnosis

FIGO/AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Not yet determined (requires additional diagnostic procedures)
- ☐ Other (please circle): cervical polyps adenocarcinoma Other gynecological cancer Other pelvic abnormality

Client Notified of Results: (___ /___/ ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow routine screening
- ☐ Short-term follow-up
- ☐ Repeat Pap smear immediately
- ☐ Colposcopy
- ☐ Pelvic ultrasound
- ☐ Other biopsy
- ☐ Gynecological consultation
- ☐ Obtain definitive treatment
- ☐ Hysterectomy
- ☐ LEEP/Cone

Final Diagnosis

- ☐ Normal/Benign reaction/Inflammation
- ☐ HPV/Condylomata/Atypia
- ☐ Low Grade SIL (biopsy diagnosed)
- ☐ High Grade SIL (biopsy dx.)
- ☐ CIN I/mild dysplasia (biopsy dx.)
- ☐ CIN II/moderate dysplasia (biopsy dx.)
- ☐ CIN III/severe dysplasia/carcinoma in situ stage 0 (biopsy dx.)
- ☐ Invasive cervical carcinoma (biopsy dx.)

Stage at diagnosis

FIGO/AJCC		Summary		Tumor Size:
☐ Stage 1		☐ Local		☐ 0-<1cm
☐ Stage 2	or	☐ Regional	AND	☐ 1-<2cm
☐ Stage 3		☐ Distant		☐ 2-<5cm
☐ Stage 4		☐ Unknown		☐ 5+cm
				☐ unknown

- ☐ Not yet determined (requires additional diagnostic procedures)
- ☐ Other (please circle): cervical polyps adenocarcinoma Other gynecological cancer Other pelvic abnormality

Client Notified of Results: (___ /___/ ____)
Month Day Year

Recommendations (circle all that apply)

- ☐ Follow routine screening
- ☐ Short-term follow-up
- ☐ Repeat Pap smear immediately
- ☐ Colposcopy
- ☐ Pelvic ultrasound
- ☐ Other biopsy
- ☐ Gynecological consultation
- ☐ Obtain definitive treatment
- ☐ Hysterectomy
- ☐ LEEP/Cone

Final Diagnosis and Treatment Information

Status of Final Diagnosis

(to be completed after final diagnosis has been determined)

- ☐ Work-up pending
- ☐ Work-up complete (___ /___/ ____) Month Day Year
- ☐ Lost to follow-up
- ☐ Work-up refused (___ /___/ ____) Month Day Year

Status of Treatment

(to be completed if cancer is diagnosed)

- ☐ Treatment pending
- ☐ Treatment started (___ /___/ ____) Month Day Year
- ☐ Lost to follow-up
- ☐ Treatment not needed (___ /___/ ____) Month Day Year

Claims Forms

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____ . __ 3. ____ . __ 2. ____ . __ 4. ____ . __		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a												A
b												B
												C

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
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	b	.		.		.
	c	.		.		.
	d	.		.		.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1						.	.		1
2						.	.		2
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	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR P AYMENTS	55 EST. AMOUNT DUE	56	
A					.	.		A
B					.	.		B
C					.	.		C
	57				.	.		

DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GR OUP NAME	62 INSURANCE GR OUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLO YER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		

	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID	
	C		D		E		A	a
								b
							OTHER PHYS. ID	a
							B	b

	84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
a			
b		X	
c			
d			

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

BCC Medicaid Forms

BCC-MEDICAID APPLICATION COVER SHEET

All documents must be complete, signed and LEGIBLE

Check to make certain that all of the following are included with BCC Medicaid Application:

- ☐ WHC Enrollment form (current)
- ☐ Under 50 approval – (if applicable)
- ☐ Presumptive Eligibility form
    - Breast or cervical cancer section –
        - date and result of Pap/ CBE /Mammogram
        - **date and result of biopsy,** final diagnosis
    - Initial plan of care
    - Treatment start date if known – or TB Determined
    - Physician name(s) and phone numbers
    - Case Manager's signature and phone number
- ☐ BCC-Medicaid Verification form (citizenship/insurance status)
    - Signed and dated by client (in 2 places)
- ☐ Alien document with **Alien ID #** (if non- citizen)
    - Copy front and back
- ☐ Screening, Abnormal Follow-Up forms, pathology (**biopsy**) report, other relevant reports notes

Applications without a biopsy report are not valid.

Idaho Department of Health and Welfare **11-02-04**

ATTN: Benefit Program Operations **Phone: (208) 334-5818** **Fax: (208) 334-4916**

Breast and Cervical Cancer
Medicaid Verification

Part 1: Citizenship/Alien Status Declaration
(The potentially eligible woman must complete the following information)

The information we need does not stop or limit the services you receive from Women's Health Check. We need the information to figure your eligibility for Medicaid help with all your health costs. You are not required to apply for Medicaid. The information you give us for Medicaid will not be reported to the U.S. Department of Homeland Security's Bureau of Citizenship and Immigration Services, formerly known as Immigration and Naturalization Service (INS).

Name: _____ **SSN:** _____
(Please print)

☐ **I am a U.S. citizen.**

☐ **I am not a U.S. citizen. My Alien ID # is** _____

➔ **Copy both sides of Alien ID card and attach.**

Signature: _____ **Date:** _____

Part 2: Request for Creditable Insurance Determination
(The person determining eligibility completes the following information)

Most health coverage is creditable coverage, including prior coverage under a group health plan (including governmental or church plan), health insurance coverage (either group or individual), Medicare, Medicaid, a military-sponsored health care program, a program of the Indian Health Services, a State high risk pool, the Federal Employee Health Benefit Program, a public health plan, and a health benefit plan provided for Peace Corps members. Creditable coverage does not include coverage consisting solely of excepted benefits such as coverage only for accidents, disability income insurance, liability insurance, supplemental policies to liability insurance, worker's compensation insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or limited-scope dental, vision, or long-term care insurance. There may also be limited circumstances where a woman has creditable coverage, but she is not actually covered for treatment of breast or cervical cancer. For example, if a woman has creditable coverage but is in a period of exclusion (such as preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer, she is not considered covered for this treatment. If a woman who has creditable coverage exhausts her lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer, she is not considered covered for this treatment. In these circumstances, the woman may be eligible for Medicaid coverage.

Section 1:

☐ **I do not have health insurance. Signature:** _____ **Date:** _____

☐ **I do have health insurance.** ***Please complete the information below:***

Please complete this form and attach a copy of the insurance card. Incomplete forms will be returned to WHC.		
Name of Subscriber	**SSN of Subscriber**	**Birth Date of Subscriber**
Name of Insurance Company	**Phone Number of Insurance Company**	**Copy of Insurance Card (front and back)**
Full Name of Potentially Eligible Woman	**Birth Date of Potentially Eligible Woman**	**Case Number of Potentially Eligible Woman**

Section 2: To be completed by Medicaid

Date Received:	**Spoke With:**
Does The Insurance Policy Cover:	
In-Patient Care:	**Lab/X-Ray Services:**
Out-Patient Care:	**Physician Services:**
Is the potentially eligible woman in a period of exclusion for breast or cervical cancer treatment?	**Has the potentially eligible woman exhausted her lifetime limit on all benefits under the plan/coverage?**

Comments:

This insurance should ____ should not ____ be considered a creditable insurance.

Reviewed by: _____ Date: _____.

Departamento de Salud y Bienestar de Idaho **11-02-04**

ATTN: Operaciones del Programa de Beneficios **Teléfono: (208) 334-5818** **Fax: (208) 334-4916**

Cáncer del Pecho y Cuello Uterino
Verificación de Medicaid

Parte 1: Declaración del Estado de Ciudadanía/Extranjero
(La mujer potencialmente elegible debe completar la siguiente información)

La información que nosotros necesitamos no impide o limita los servicios que usted recibe del Control de la Salud para las Mujeres (Women's Health Check). Necesitamos la información para pronosticar su elegible para la ayuda de Medicaid con todos los costos de su salud. No se le requiere que solicite Medicaid. La información que nos de para Medicaid no será reportada al Departamento de Seguridad de la Nación de EE.UU. Agencia de Servicios de Inmigración y Ciudadanía, anteriormente conocida como Servicios de Inmigración y Naturalización (INS).

Nombre: _____ **NSS:** _____
(Por favor escriba en letra de molde)

☐ **Yo soy ciudadano de EE.UU.**

☐ **Yo no soy ciudadano de EE.UU. Mi # de ID de Extranjero es** _____

➔ **Copie ambos lados de la tarjeta de ID de Extranjero y adjúntela.**

Firma: _____ **fecha:** _____

Parte 2: Solicitud una Determinación de Seguro Acreditado
(La persona que determina la elegibilidad completa la siguiente información)

La mayoría de coberturas de salud son coberturas acreditadas, incluyendo coberturas previas bajo un plan de salud en grupo (incluyendo planes gubernamentales o de la iglesia),cobertura de seguro médico (ya sea en grupo o individuales), Medicare, Medicaid, programa de seguro médico patrocinado por militar, un programa de los Servicios de Salud para los Indios Nativos, un grupo del alto riesgo Estatal, el Programa Federal de Beneficios de Salud para los Empleados, un plan de salud publica, y un plan de beneficios de salud dado para los miembros del Cuerpo de Paz. Cobertura acreditada no incluye cobertura compuesta únicamente de beneficios exceptuados tales como cobertura solo por accidente, seguro de discapacidad de tener ingresos, seguro de responsabilidad personal, pólizas complementarias de seguro de responsabilidad personal, seguro de compensación a los trabajadores, seguro del automóvil para pagos médicos, seguro únicamente para crédito, cobertura para clínicas medicas en el lugar, o seguro limitado a examen dental, de la vista, o cuidados a largo plazo. Puede también haber circunstancias limitadas donde una mujer tiene cobertura acreditada, pero ella no esta actualmente cubierta por tratamiento de cáncer cervical o del pecho. Por ejemplo, si una mujer tiene cobertura acreditada pero esta en un periodo de exclusión (tal como exclusión de condición pre-existente o un periodo de afiliación a HMO) para tratamiento de cáncer cervical o del pecho, ella no es considerada cubierta para este tratamiento. Si una mujer tiene cobertura acreditada y agota su límite vital sobre todos los beneficios bajo el plan o cobertura, incluyendo tratamiento de cáncer cervical y del pecho, ella no es considerada cubierta para este tratamiento. En estas circunstancias, la mujer puede ser elegible para cobertura por Medicaid.

Sección 1:

☐ **Yo no tengo seguro médico.** **Firma:** _____ **Fecha:** _____

☐ **Yo tengo seguro medico. Por favor complete la información de abajo:**

Por favor llene esta forma y adjunte una copia de la tarjeta del seguro. Formas incompletas serán devueltas a WHC.		
Nombre del Suscriptor	**NSS del Suscriptor**	**Fecha de Nacimiento del Suscriptor**
Nombre de la Compañía de Seguros	**Número de Teléfono de la Compañía de Seguros**	**Copia de la Tarjeta de Seguro (frente y reverso)**
Nombre completo de la mujer Potencialmente Elegible	**Fecha de Nacimiento de la Mujer Potencialmente Elegible**	**Número del Caso de la Mujer Potencialmente Elegible**

Sección 2: Será completada por Medicaid

Fecha Recibida:	**Hablé Con:**
La Póliza de Seguro Cubre:	
Cuidados en el Hospital:	**Servicios de LAB/Rayos X:**
Cuidados en Consulta Externa:	**Servicios Médicos:**
¿Esta la mujer potencialmente elegible en un periodo de exclusión para tratamiento de cáncer cervical o del pecho?	**¿La mujer potencialmente elegible ha agotado su límite durante su vida de todos los beneficios bajo el plan/cobertura?**

Comentarios: _____

_____

Este seguro debería ____ no debería ____ ser considerado un seguro acreditado.

Revisado por: _____ **Fecha:_____.**

Presumptive Eligibility Form

Idaho – Medicaid

vers. (02.17.2005)

Women's Health Check
Bureau of Clinical and Preventive Services
4th Floor, PO Box 83720, BOISE, ID 83720-0036

Client Name: _____ _____ _____ **Date of Birth:** (____/___/_____)
Nombre Last (Print) First MI *Fecha de Nacimiento* Month Day Year

Age: ____ **Date of Initial WHC Enrollment:** (___/__/_____) **Social Security #:**
Edad Month Day Year *Seguro Social #* __ __ __ - __ __ - __ __ __ __

- ❑ Client apparently has no insurance that will cover treatment for this diagnosis
- ❑ Screening and Diagnostic services were provided through Women's Health Check
- ❑ Client was found to need treatment for breast or cervical cancer

Breast Cancer / Caner del Seno

Date of clinical breast exam: (____/____/_____)
Month Day Year

CBE results: _____

Date of mammogram: (____/____/_____)
Month Day Year

Mammogram results: _____

Date of biopsy: (____/____/_____)
Month Day Year

Biopsy results: _____

Final diagnosis/*Diagnóstico final*:

- ❑ Carcinoma *in situ*
- ❑ Ductal Carcinoma *in situ*
- ❑ Lobular Carcinoma *in situ*
- ❑ Invasive Breast Cancer

Cervical Cancer / Cáncer Cervical

Date of Pap Smear: (____/____/_____)
Month Day Year

Pap Smear results: _____

Date of biopsy: (____/____/_____)
Month Day Year

Biopsy results: _____

Final diagnosis/*Diagnóstico final*:

- ❑ LG SIL (CIN I/Mild dysplasia) - treatment recommended
- ❑ HG SIL (CIN II/Moderate dysplasia)
- ❑ HG SIL (CIN III/Severe dysplasia/CIS)
- ❑ Carcinoma

Initial Plan of Care / Plan Inicial de Cuidado

	Physician (Print)	**Telephone**	**Appointment Date**
❑ Surgery	_____	_____	_____
❑ Radiation	_____	_____	_____
❑ Chemotherapy	_____	_____	_____
❑ Other _____	_____	_____	_____

Treatment Start Date/ *Fecha de Inicio del Tratamiento:* (____/____/_____)
Month Day Year

❑ Client received information packet _____ *initial*

❑ Reviewed information packet with client _____ *initial*

Consent for Release of Information: I give permission to the Idaho Department of Health and Welfare to tell the local WHC program whether my Medicaid Application is approved, denied, or coverage ended for the purpose of planning for my continuing care. ***Date***: _____

☞ ***Client Signature***: _____

Consentimiento para la Liberación de Información: Yo le doy permiso al Departamento de Salud y Bienestar de Idaho para dejarle saber al programa de Women's Health Check local si mi solicitud de Medicaid ha sido aprobada, negada o si la cobertura ha terminado, para poder planear mi cuidado de salud. *Fecha* _____

Firma de la Cliente _____

The above-named client has been screened and diagnosed with breast or cervical cancer through the Women's Health Check (WHC) program, a part of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), and is applying for Medicaid as a special group recognized through the BCCPTA.

_____ _____ _____
Certified by (Women's Health Check, local Case Manager) Phone Date

_____ _____
Verified by (Women's Health Check, state office) Date

WHC Screening Reimbursement
For Clients on BCC Medicaid

Women in the Breast and Cervical Cancer Treatment Program may need annual screening not covered by Medicaid. Medicaid reimburses for a yearly mammogram for women over 40. Appointments for clinical breast exam and Pap test are not covered unless there is a problem. Women's Health Check will reimburse for authorized screening services not covered by Medicaid.

This notifies the Third Party Administrator that the client is covered for this service by WHC.

_ _

Reimbursement Request
Women's Health Check Screening Services

(Not covered by Breast and Cervical Medicaid Treatment Program)

Client name: ________________________________

Birth Date: __________________________________

☐Mammography ☐Office visit for clinical breast/pelvic exam ☐Pap test

Date of Service: ______________________________

Provider: ____________________________________

LCC location: _______________

***ATTACH to claim or FAX to United Group Programs (UGP) 561-997-9927**

10.05

National Breast and Cervical Treatment Act
Request for Transfer Form

Idaho

Instructions: Clients diagnosed through another state or tribe funded by the Centers of Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) may request a transfer from that state's Medicaid system to Idaho. Submit the following for review prior to acceptance:

1. **Idaho WHC Enrollment Form**
2. **Presumptive Eligibility Form Idaho – Medicaid**
3. **Breast and Cervical Cancer Medicaid Verification Form**
4. **Request for Transfer Form – Date of diagnosis, current treatment status, physician**
5. Submit forms and information to a local WHC coordinator, or the state WHC office:
   Women's Health Check
   450 West State Street – 4th Floor
   PO Box 83720
   Boise, ID 83720-0036 Telephone: 208 334-5971 **FAX 208 334-0657**
6. Enrollment will be approved based upon **Idaho eligibility requirements** and **treatment status**. Idaho requirements may be different from original enrollment state.

Client Name (Last, First, M.I.)_____

Birth Date _____

Social Security #: __ __ __ - __ __ - __ __ __ __

Previous Address (City)_____**(State)**_____

Previous NBCCEDP affiliate (State or Tribe):_____

Date of Enrollment at previous site: _____**Date of Diagnosis:** _____

Name of Physician _____ **Phone Number** _____

Current Treatment: _____

I consent to the release of my information to the Idaho Department of Health and Welfare Women's Health Check and Medicaid for the purpose of determining eligibility and transfer of records to Idaho Medicaid for the duration of active treatment for breast or cervical cancer, diagnosed through another affiliate of the NBCCEDP.

Signature: _____ **Date:** _____

Resources

RESOURCES

This is a brief list of useful websites and reports regarding cancer. Specific resources related to breast or cervical cancer can be found in following sections.

REPORTS

National Breast and Cervical Cancer Early Detection Program
1991-2002 National Report
http://www.cdc.gov/cancer/nbccedp/Reports/NationalReport/index.htm

PUBLIC HEALTH

The Guide to Clinical Preventive Services
http://odphp.osophs.dhhs.gov/pubs/guidecps/

Centers for Disease Control and Prevention Cancer Web Site
www.cdc.gov/cancer

Cancer Information Service
http://cis.nci.nih.gov/

American Cancer Society
http://www.cancer.org

RESOURCES FOR BREAST CANCER

This is a brief list of useful websites and reports regarding breast and cervical cancer screening.

RESOURCES FOR BREAST CANCER

PROFESSIONAL:

American College of Radiology – Bi-Rads Atlas
http://www.acr.org/s_acr/sec.asp?CID=97&DID=142

National Comprehensive Cancer Network – Clinical Practice Guidelines in Oncology
Breast Cancer Screening and Diagnosis Guidelines version 1.2005
http://www.nccn.org/professionals/physician_gls/PDF/breast-screening.pdf

American Cancer Society
www.cancer.org

National Cancer Institute
http://www.cancer.gov/cancertopics/types/breast

U.S. Preventive Services Task Force
Pocket Guide to Clinical Preventive Services
http://www.preventiveservices.ahrq.gov/

Centers for Disease Control & Prevention
www.cdc.gov/cancer/nbccedp/info-bc.htm

National Cancer Institute
Breast Cancer (PDQ®): Screening (Health Professional Version)
www.cancer.gov/cancertopics/pdq/screening/breast/healthprofessional/allpages/print
Digital vs. Film Mammography in the Digital Mammographic Imaging Study (DMIST): Questions & Answers
www.cancer.gov/newscenter/pressreleases/DMISTQandA

Public Health Grand Rounds
Breast Cancer Screening: More than Just Mammograms (webcast)
http://publichealthgrandrounds.unc.edu/brcancer/index.htm

MedLine Plus (National Library of Medicine)
Breast Cancer Home Page
www.nlm.nih.gov/medlineplus/breastcancer.html

Guide to Clinical Preventive Services
http://odphp.osophs.dhhs.gov/pubs/guidecps/

PATIENT:

American Cancer Society
www.cancer.org
Brochures of Interest:

- After Diagnosis: A Guide for Patients and Families — English (#9440)
- Breast Cancer Dictionary — English (#4675)

- Breast Cancer Treatment Guidelines for Patients, Version VI English/Spanish (#9405/9406)
- Sexuality & Cancer: For the Woman Who Has Cancer & Her Partner English (#4657)

Centers for Disease Control & Prevention
www.cdc.gov/cancer/nbccedp/info-bc.htm

National Cancer Institute
http://www.cancer.gov/cancertopics/types/breast
Brochures of Interest:
What You Need to Know About Breast Cancer
www.cancer.gov/cancertopics/wyntk/breast
Understanding Breast Changes: A Health Guide for All Women
www.cancer.gov/cancertopics/understanding-breast-changes
Breast Cancer (PDQ®): Screening (Patient Version)
www.cancer.gov/cancertopics/pdq/screening/breast/patient/allpages/print
Fact Sheet: Screening Mammograms: Questions & Answers
http://www.cancer.gov/cancertopics/factsheet/Detection/screening-mammograms
Fact Sheet: Improving Methods for Breast Cancer Detection & Diagnosis
http://www.cancer.gov/cancertopics/factsheet/Detection/breast-cancer

MedLine Plus (National Library of Medicine)
Breast Cancer Home Page
www.nlm.nih.gov/medlineplus/breastcancer.html

RESOURCES FOR CERVICAL CANCER

This is a brief list of useful websites and reports regarding cervical cancer.

RESOURCES FOR CERVICAL CANCER

PROFESSIONAL:

National Comprehensive Cancer Network – Clinical Practice Guidelines in Oncology
Cervical Screening version 1.2005
http://www.nccn.org/professionals/physician_gls/PDF/cervical_screening.pdf

American Society for Colposcopy and Cervical Pathology
Consensus Guidelines
http://www.asccp.org/

American Cancer Society
www.cancer.org

National Cancer Institute
www.cancer.gov/newscenter/pressreleases/cervicalscreen

Cervical Cancer (PDQ®): Screening (Health Professional Version)
www.cancer.gov/cancertopics/pdq/screening/cervical/healthprofessional/allpages/print

U.S. Preventive Services Task Force
www.ahrq.gov/clinic/uspstf/uspscerv.htm

Centers for Disease Control and Prevention
www.cdc.gov/cancer/nbccedp/info-cc.htm

Guide to Clinical Preventive Services
http://odphp.osophs.dhhs.gov/pubs/guidecps/

MedLine Plus (National Library of Medicine)
Cervical Cancer Home Page
www.nlm.nih.gov/medlineplus/cervicalcancer.html

PATIENT:

American Cancer Society
www.cancer.org

National Cancer Institute
www.cancer.gov/cancertopics/types/cervical
Brochures of Interest:
What You Need to Know About Cancer of the Cervix
www.cancer.gov/cancertopics/wyntk/cervix
Understanding Cervical Changes: A Health Guide for Women
www.cancer.gov/cancertopics/understandingcervicalchanges
Cervical Cancer (PDQ®): Screening (Patient Version)
www.cancer.gov/cancertopics/pdq/screening/cervical/patient/allpages/print

Fact Sheet: Pap Test: Questions & Answers
http://www.cancer.gov/cancertopics/factsheet/Detection/Pap-test
Pap Tests and Cervical Health: A Health Habit for You
http://www.cancer.gov/cancertopics/pap-tests-cervical-health
Pap Tests for Older Women
http://www.cancer.gov/cancertopics/pap-tests-older-women

Centers for Disease Control and Prevention
www.cdc.gov/cancer/cancer/nbccedp/info-cc.htm

MedLine Plus (National Library of Medicine)
Cervical Cancer Home Page
www.nlm.nih.gov/medlineplus/cervicalcancer.html

Glossary

GLOSSARY OF TERMS/ABBREVIATIONS

American College of Radiology Accreditation (ACR)
A voluntary mammography accreditation program has become one of the standards for quality assurance. The following major areas are assessed:

- Personnel qualifications and experience
- Equipment specification and technical procedures
- Quality assurance practices
- Evaluations of mammograms from the applicants practice and through the use of phantom images

Adult Preventive Health Program (APHP)
Qualis Health's Adult Preventive Health Program – free software designed to manage patient health care. Required for client data entered by WHC Local Coordinating Contractor (LCC).

Aspiration Biopsy
A procedure in which a specimen for biopsy is removed by aspirating it through an appropriate needle that pierces the skin and penetrates into the underlying tissue to be examined. (Also see Fine Needle Aspiration) or A procedure where an appropriate needle pierces the skin penetrating into the underlying tissue to be examined and a specimen for biopsy is removed by aspiration.

Benign
This is not malignant; not recurrent; favorable for recovery; not cancer. The main types of benign breast problems are fibroadenoma, fibrocystic changes and cysts.

Bethesda System
A method for the reporting and classification of Pap smear specimens, developed in December 1988. The Clinical Laboratory Improvement Act (CLIA) regulations mandate the use of the Bethesda System for laboratory reporting and proficiency testing.

Biopsy
The removal and examination (by a pathologist) of tissue samples, cells, or fluids from a living body. An examination of the appearance of the tissue under a microscope is done to find out if cancer or other abnormal cells are present. The biopsy can be done with a needle or by surgery.

BIRAD
Uniform reporting system for mammography results.

Breast Cancer
Cancer that begins in the breast. The main types of breast cancer are Ductal Carcinoma in Situ, Infiltrating Ductal Carcinoma, Lobular Carcinoma in Situ, Medullary Carcinoma and Paget's disease of the nipple.

Breast Self Examination (BSE)
A technique of checking your own breasts for lumps or suspicious changes.

Carcinoma
This is a malignant tumor that begins in the lining (epithelial) cells of organs. Epithelial cells are those which cover the surfaces of tissue. It can occur in any part of the body. 80% or more cancers and all breast cancers are carcinoma.

Carcinoma in Situ

An early stage of cancer in which the cancer is still only in the structures of the organ where it developed and the disease has not invaded other parts of the organ or spread. Most are highly curable. Also called cancer in situ and preinvasive.

Case Manager
The member of the cancer care team who is the "referee." This person coordinates all of the services needed by the client throughout diagnosis, treatment, and recovery.

Clinical Breast Examination (CBE)
A physical examination of the breasts performed by a physician, nurse or physician's assistant.

Cervical Intraepithelial Neoplasia (CIN)
A cellular change to the mouth of the cervix which may include severe dysplasia and CIS. CIN III is the most severe of the three-category classification system.

Colposcope
An instrument used to examine the tissues of the vagina and cervix through a magnifying lens.

Colposcopy
Diagnostic procedure performed with a Colposcope through a magnified view of the vagina/cervix to visualize abnormal epithelium for biopsy and/or removal in clients with abnormal pap smears. Cervical biopsies are usually done through colposcopic examination.

Cone Biopsy
The removal of the cone shaped piece of tissue from the cervix. This is a more definitive procedure than a cervical biopsy. It is used when abnormal cells extend up into the cervical opening or through the tissue.

Conization
The process of removing a cone of tissue, as in partial excision of the cervix uteri. Cold Conization is done with a cold knife to better preserve the histologic elements.

Contractors
Idaho Health Districts, clinics, hospitals and other health-related agencies that contract directly with the State Women's Health Check Program (WHC) to coordinate breast and cervical cancer early detection services and data. Each contractor must have formal agreements or subcontracts with all providers for WHC services.

Cryosurgery
This is the destruction of tissue by exposing tissues to extreme cold in order to produce well-demarcated areas of cell injury and destruction. Used to treat malignant tumors, control pain, produce lesions in the brain, and control bleeding.

Diagnostic Mammogram
Defined by the American College of Radiology as "mammography performed on women who, by virtue of symptoms or physical findings, are considered to have a substantial likelihood of having breast disease."

Ductal Carcinoma in Situ
Cancer cells that started in the milk ducts and have not penetrated the duct walls into the surrounding tissue. This is a highly curable cancer form of breast cancer that is treated with surgery.

Dysplasia
This is an abnormality in size, appearance and organization of adult cells. A biopsy is needed for diagnosis.

Endocervical Curettage (ECC)
The surgical scraping of the lining of the uterine cervix.

"Every Woman Matters" Legislation
Idaho law that allows women diagnosed with breast or cervical cancer through the Women's Health Check program to apply for Medicaid (if eligible) while receiving active treatment.

Fibroadenoma
An adenoma in the breast, composed of fibrous tissue. On clinical examination or BSE, it feels like a firm lump. These usually occur in young women and are benign.

Fibrocystic Changes
A term that describes certain benign changes in the breast. Symptoms are breast swelling or pain. Signs are nodules, lumpiness and nipple discharge. Not cancerous.

Federal Poverty Level (FPL)
This measurement is updated annually based on the last calendar year's increase in prices as measured by the Consumer Price Index. A woman is eligible for the Women's Health Check program if her income is at or below 200% of the FPL.

Grade
The classification of the severity of a disease.

Human Papillomavirus (HPV)
A sexually transmitted virus implicated in the pathogenesis of cervical cancer and its pre-cursor lesions.

High-Grade Squamous Intraepithelial Lesion (HSIL)
The Bethesda System classification for a Pap smear result that includes cellular changes of moderate to severe dysplasia (CIN II and III / CIS).

Hyperplasia
An abnormal increase in the number of cells in a specific area, such as the lining of the breast ducts. This overgrowth may be due to hormonal stimulation, injury or continuous irritation. It is not cancerous by itself, but when the proliferating cells are atypical the risk of cancer developing is greater.

Infiltrating Ductal Carcinoma
A cancer that starts in the milk passages of the breasts (ducts) and then breaks through the duct wall, where it invades the fatty tissue of the breast. When it reaches this point, it has the potential to spread or metastasize elsewhere in the breast, as well as to other parts of the body through the bloodstream and lymphatic system. Infiltrating ductal carcinoma is the most common type of breast cancer, accounting for about 80% of breast malignancies.

Invasive Cancer
This is a cancer that has invaded surrounding tissue and spread to distant parts of the body.

Invasive Cervical Carcinoma
Infiltration of cancer cells into the tissue beyond the epithelium of the cervix. This term indicates that a malignant growth extends deeper than 3 mm into the stroma.

Invasive Lobular Carcinoma
A cancer that arises in the milk-producing glands of the breast and then breaks through the lobule walls. From this site it may spread elsewhere in the breast. 15% of invasive breast cancer is ILC. It is often difficult to detect by physical examination or even by mammography. Up to 25% of women with this type of cancer will at some point develop an additional cancer in the opposite breast.

Local Coordinating Contractor (LCC)
Health District, contracting clinic, hospital or other health related agency that contracts with State of Idaho Dept. of Health and Welfare, Women's Health Check program to coordinate local services and report client data.

Loop Electrosurgical Excision Procedure (LEEP)
A surgical procedure used on the cervix by which an electrical current generating a radio frequency, is passed through a wire loop, which is then drawn around the cervical opening to excise the tissue. The procedure can usually be performed in an outpatient setting with the use of local anesthesia. (Procedure not paid for by WHC.)

Lobular Carcinoma in Situ (LSIL)
A very early type of breast cancer developing within the milk-producing glands (lobules) of the breast and does not penetrate through the wall of the lobules. Researchers think that lobular carcinoma in situ does not eventually become an invasive lobular cancer. They believe, instead, that it places women at an increased risk of developing an invasive breast cancer later in life. This makes it important for women with lobular carcinoma in situ to have a physical examination three to four times per year and an annual mammogram.

Lobular Carcinoma (infiltrating or invasive)
A type of breast cancer that starts within the lobules. It may be multicentric (occurring in multiple lobules). Compared with other types of breast cancer, this type has a higher chance of occurring in the opposite breast as well. It can often be difficult to diagnose, even with careful physical examination or mammography.

Low-Grade Squamous Intraepithelial Neoplasia (LSIL)
The Bethesda System classification for a Pap smear result, which includes cellular changes of HPV, mild dysplasia (CIN I).

Lumpectomy
Removal of the breast lump plus a margin of normal tissue around it. If tissue is found to be malignant, radiation therapy or mastectomy often follows it. Also called Limited Breast Surgery.

Mammography Quality Standards Act of 1992 (MQSA)
The national accreditation of mammogram units through the FDA.

MDE (Minimum Data Elements)
Clinical data items submitted to CDC two times a year.

Metaplasia
This is an abnormal replacement of cells of one type by cells of another type. This does not represent a malignant or premalignant condition.

Metastasis
The spread of cancer cells to distant areas of the body by way of the duct extension, lymph system or bloodstream.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)
National breast and cervical cancer screening program funded by the Centers for Disease Control and Prevention. Idaho's program is known as Women's Health Check.

Needle Aspiration
Removal of fluid from a cyst or cells from a tumor. In this procedure, a needle and syringe (like those used to give injections) is used to pierce the skin, reach the cyst or tumor, and with suction, draw up (aspirate) specimens for biopsy analysis. If the needle is thin, the procedure is called Fine Needle Aspiration (FNA).

Needle Localization
A procedure used to do a breast needle biopsy, when the lump is difficult to locate or in areas that look suspicious on the x-ray but do not have a distinct lump. After an injection of local anesthesia to numb the area, a thin needle is inserted into the breast. X-rays are taken and used to guide the wire to the area to be biopsied. A tiny hook on the end of the wire holds it in place. Then a hypodermic needle (like the type used to give injections) is inserted, using the path of the wire as a guide, and the biopsy is completed. (Also see Needle Aspiration)

Neoplasia
The pathologic process that results in the formation and growth of a neoplasm. This neoplasm is a new growth or tumor, which may be benign or malignant.

Neoplasm
Any abnormal growth; neoplasms may be benign or malignant. Cancer is a malignant neoplasm.

Nipple Discharge
Any fluid coming from the nipple. It may be clear, milky, bloody, tan, gray, or green.

Nodule
A small, solid lump that can be located by touch.

Pap (Papanicolaou) Smear (Pap Test)
This is a screening test of the cells of the cervix used to detect early signs of cervical cancer.

Premalignant
Abnormal changes in cells that may, but not always, become cancer. Most of these early lesions respond well to treatment and result in cure. Also called precancerous.

Protocol
This is a formalized outline or plan.

Providers
Health Care Professionals, labs, mammography centers, or hospitals that contract with the State of Idaho Department of Health and Welfare, Women's Health Check program to provide services for WHC clients. Listed services for enrolled clients are reimbursed at Medicare rates.

Reactive Changes
Normal changes in tissue as a result of the body's reaction to an irritation or infectious agent.

Rescreening
The process of returning for cancer screening test (clinical breast exam, mammogram, Pap test) at a predetermined interval – usually once per year.

Screening Mammogram
American College of Radiology defines a screening mammogram as an "x-ray breast examination of asymptomatic women in an attempt to detect breast cancer, when it is small, nonpalpable and confined to the breast."

Screening Services
Refers to clinical breast examination, Pap smear, pelvic examination, mammography, colposcopy, colposcopy directed biopsy, fine needle aspiration, instruction in breast self-examination and informational and educational services relating to breast and cervical cancer.

Squamous Cell Carcinoma
Develops from squamous epithelium. Initially local and superficial, may later invade and metastasize.

Staging
A method of determining and describing the extent of cancer, based on the size of the tumor, whether regional axillary lymph nodes are involved, and whether distant spread (metastasis) has occurred. Knowing the stage at diagnosis helps decide the best treatment and the prognosis.

Stages of Breast Cancer (FIGO/AJCC (1988)

- Stage 0: The earliest type of breast cancer; the disease is in situ.
- Stage I: The tumor is less than 1 inch in diameter and has not spread beyond the breast.
- Stage II: The tumor is about 1-2 inches in diameter and/or has spread to the lymph nodes under the arm (axillary lymph nodes).
- Stage III: The tumor is about 2 inches or larger and may have spread to axillary lymph nodes, and/or to other lymph nodes, or to other tissues near the breast.
- Stage IV: The cancer has spread (metastasized to other organs of the body).

Stereotactic Biopsy
A diagnostic procedure that combines the technology of radiological imaging with surgical biopsy. This procedure may be used to obtain tissue from a lesion that is probably benign, but has changed during repeated mammograms, and the patient wishes to avoid more extensive excisional surgery. It is often used to obtain tissue for biopsy from suspicious clusters of mammographic calcifications.

Suspicious Abnormality
A finding on a test that indicates cancer might be present.

Third Party Administrator (TPA)
Agency that reviews and pays all claims from providers for the Women's Health Check Program.

US - Ultrasonography (ultrasound)
An imaging method in which high-frequency sound waves are used to outline a part of the body. It is useful in detecting breast cysts in young women with firm, fibrous breasts. No radiation exposure occurs.

Within Normal Limits (WNL)
An interpretation of a cervical cancer screening or diagnostic procedure result, and it indicates negative findings.

Women's Health Check (WHC)
Idaho's program to implement the National Breast and Cervical Early Detection Program managed and funded through CDC.

Provider Updates

PROVIDER UPDATES

This Update is intended as a supplement to the WHC Provider Manual. We welcome your questions and will address them in future notices. Please send e-mail regarding WHC Provider Update to MaddoxP@idhw.state.id.us with your questions. For immediate assistance, you may call Women's Health Check at (208) 334-5805.

WHC Program Provider Updates

July 1, 2004

Thanks to **YOU**, *Women's Health Check* has provided breast and cervical cancer screening/diagnostic tests to 3,000 women throughout Idaho during the past 12 months. In addition, 61 women have been able to access Medicaid treatment for cancer identified through *Women's Health Check*. These women have limited income, are under-insured, and meet the age guidelines for screening with these federal funds. The quality of services and adequate follow-up of abnormal results has been excellent. You are making an important difference in the lives of Idaho women and their families. *Thank you!*

Q & A

Q: What can I do to ensure reimbursement?	A: Submit claims for *WHC* authorized CPT codes within 90 days of service. When *WHC* is listed in a billing "system" as payor, services other than those reimbursable by *WHC* are often sent to UGP for payment. These claims are denied, costing the *WHC* Program $7 for each claim denied.
Q: When a woman has a solid dominant mass that is suspicious for cancer and has a normal mammogram, is it necessary to do further diagnostic workup?	A: Yes! A normal mammogram does not eliminate the need for further evaluation. Repeat CBE by a surgeon; ultrasounds; biopsy or aspiration is needed for adequate follow up.* **Except from Evaluation of Common Breast Problems: A Primer for Primary Care Providers.*
Q: Why is ductoscopy not reimbursed?	A: Fiberoptic ductoscopy is currently being used in clinical trials and research and is still considered experimental and investigational as cited in an Aetna Health Bulletin. It is not designed to replace mammography. Clients should not be billed for this procedure.
Q: Do women over 65 need Pap testing?	A: If there have been 3 consecutive normal pap tests, and no abnormal Pap in the last 10 years, a recommendation to discontinue can be considered* **National Cancer Institute"*
Q: Why is the liquid-based Pap (88142) listed with conventional Pap (88164) on the WHC Reimbursement sheet at $14.76 when Medicare reimbursement rate is $28.31?	A. The *WHC* Program, a population-based screening program, receives it's funding from the national Program at the Centers for Disease Control and Prevention. While liquid based technology has advantages in some circumstances, the added cost would limit the number of women who could be screened through the breast and cervical cancer screening programs. You may perform a liquid-based Pap, however *WHC* is only authorized to reimburse at the conventional Pap rate which is still considered an adequate screening test.

Women's Health Check

WHC Program Provider Updates

July 1, 2004

Billing

There are very limited services covered by Women's Health Check. To prevent denied claims (which cost extra dollars for everyone), please remember:

- WHC is not a primary payor – services are limited to mammograms, Pap tests, annual exam, and limited diagnostic tests - please refer to the 2004 CPT code list of services covered
- **Claims (using UB-92 or CMS 1500) shall be submitted to United Group Programs within 90 days of the date of service** (per the Memorandum of Agreement you signed).
- **All claims for services provided between 7/1/03 and 6/30/04 must be submitted prior to September 1, 2004**. After that, UGP and the state will not have funds available to reimburse for those services and claims will be denied.

This Update is intended as a supplement to the *WHC* Provider Manual. Please insert this and future Updates into all manuals in your office. We welcome your questions and will address them in future notices. Please e-mail *WHC* Provider Update to MaddoxP@idhw.state.id.us with your questions. For immediate assistance, you may call *Women's Health Check* at (208) 334-5805.

We would like to ask your help in updating our provider files. If you would complete the information below and mail, fax, or e-mail the information to us.

Provider Name: _____

Primary Office Contact: _____

Address: _____

Phone: _____

Fax: _____

Billing Office Contact: _____

Fax: _____

E-mail: _____

Other staff who should receive regular updates:

Name: _____

Fax: _____

Email: _____

❒ **Please check the box if you would like to receive the *WHC Provider Update* electronically.**

WHC Program Provider Updates

October 2004

Breast Cancer Awareness Month is a very busy time and we appreciate your participation.

FYI: A radio ad promoting cervical health has been aired recently and will return in January. This may result in an increase in appointments.

A special welcome to our 12 new providers. *Thanks to you,* Idaho women without adequate resources can access breast and cervical screening, diagnosis and treatment. **Be sure to print and save the last page for a handy reference to Billing Responsibilities. (Great review for the veteran providers as well.)**

Q & A

Q: What are some restrictions to be aware of when billing for a WHC office visit?	A: The WHC program is budgeted for one office visit per year that should include a breast exam and Pap test. If screening cannot be completed in one visit, document reason when forwarding the visit information to your LCC. (LCC is responsible for entering in APHP software database.) Specimen collection (Pap) and conveyance to lab are reimbursed as part of office visit. Submitted claims for collection and conveyance will be denied and cannot be billed to the patient.
Q: Why is it important to ask for and photocopy WHC client Identification card?	A: WHC clients receive ID cards when enrolled and at yearly re-certification. It assures that she is currently eligible and lists the LCC responsible for maintaining the client's records and coordinating care. It also lists where to send claims.
Q: What do I do if I have submitted an eligible claim and have not received payment within 30 days?	A: Contact your LCC (list attached) within 90 days of original service to resolve. One possibility is that client's name was not submitted to UGP, or was spelled incorrectly. Prompt resolution of billing issues is appreciated.
Q: What do I do if a woman who meets WHC eligibility requirements is already diagnosed?	A. Only women who are screened and diagnosed through the WHC Program can be covered for treatment by a special Medicaid Program. That is why your efforts to identify eligible women and get them enrolled can make a big difference in the lives of the women in your community

Women's Health Check

WHC Program Provider Updates

October 2004

What's the difference between a Local Coordinating Contractor (LCC) and a Provider?

- Provider - Becoming a provider for WHC is a simple process – the provider needs to be linked to an LCC who is responsible for managing clients and the data. Providers may be enrolled at any time with a simple MOU that says they agree to accept Medicare rates for the acceptable CPT services and will not charge the client the difference for eligible services. You then submit claims to our third party administrator and send the results of the services to the LCC.

- LCC (Local Coordinating Contractor) - is responsible for:
  a. recruiting, determining eligibility and enrolling clients
  b. enlisting providers for needed services for breast and cervical cancer early detection and diagnosis (i.e., lab, physicians, surgeons)
  c. entering all client data in APHP system (software) and submitting database by the 15th of each month
  d. ensuring that all clients with abnormal results have appropriate follow-up (according to WHC algorithms) in a timely manner (<60 days)
  e. completing and submitting Medicaid applications to State of Idaho WHC Office when a client is diagnosed with breast or cervical cancer
  f. ensuring appropriate case management for clients with barriers or those with abnormal results.

WOMEN'S HEALTH CHECK
LOCAL COORDINATING CONTRACTORS
IDAHO HEALTH DISTRICTS

District		Address	Phone	Fax	*Coordinator **Records
1	Panhandle Health District	2195 Ironwood Ct. Coeur d'Alene, 83814	415-5100	415-5101	*Gail Turley (415-5293) **Deonn Erickson (415-5277)
2	North Central District Health	215 10th St. Lewiston, 83501	799-3100	799-0349	*/**Maggi Alsager **Theresa Mueller
3	Southwest District Health	920 Main St Caldwell, 83605/ 46 W Court Weiser ID 83672	455-5300 -C 549-2370 -W	455-5386-C 549-2371-W	*Lesli Scharbrough **Karen Douglass
5	South Central Health District	1020 Washington St. N. Twin Falls, 83301-3156	734-5900	734-9502	*Sharlynn VanTassell x235 **Charlotte Merritt x238
6	Southeast District Health	1901 Alvin Ricken Drive Pocatello, 83201	233-9080	234-7169	*Dana Bezdeka(239-5232) **Teresa Nordquist (239-5290)
7	District Seven Health Dept.	254 E Street Idaho Falls, 83402	522-0310	525-7063	*Pat Fletcher x129 **Gloria Salcido

OTHER LOCAL COORDINATING CONTRACTORS

Facility		Address	Phone	Fax	Coordinator
9	Terry Reilly Health Services	223 16th Avenue North Nampa, 83653	466-7869	466-5359	*Roxanne Ohlund (318-1260) **Di Tiffany (318-1299)
10	Family Practice Residency of Idaho	777 North Raymond Boise, ID 83704	367-6638	323/2130	*Sharene Brown
11	Saint Alphonsus Breast Care Center	6200 W. Emerald Boise, ID 83706	367-3336	367-3390	*Julie Orgill
12	Benchmark Health Services	PO Box 9088 / Moscow, 83893 1150 Alturas Drive, Suite 108 Moscow, ID 83843	877-641-4468 (877-285-6700) for Women Referred	877-641-4468	*Shelley A. Janke 310-1939 cell **Tammy Bowen-Baldwin

WHC Program Provider Updates

January 2005

It is time to mark your calendars!

May 12-13, 2005

Idaho Breast and Cervical Cancer Alliance - Annual Conference

Sun Valley Lodge, Sun Valley, Idaho

Partnerships & Patient Focused Care

Special tracks for Case Managers, Clinical Assistants, Clinicians, Health Educators, Nurses, Nurse Practitioners, Physicians, Physicians Assistants, Radiology Technologists, and Social Workers.

Featuring national and local experts in the field of breast and cervical cancer on topics such as prevention, screening, diagnostics, cultural competency skills, case management, legal issues, genetics, and art and healing. **Continuing Education Credits will be available**.

Details online soon at: www.themeetingnetworkinc.com/IBCCA2005.html

Review sessions from 2004 conference at: www.themeetingnetworkinc.com/IBCCA.html

Hosted by Idaho Breast & Cervical Cancer Alliance and Women's Health Check. Sponsors include: St. Luke's Mountain States Tumor Institute, Breast Care Services, Saint Alphonsus Breast Care Center, and the Idaho Hospital Association.

We hope you will join us in May at the Sun Valley Lodge.

WHC Program Provider Updates

January 2005

Q & A	
Q: Must all physicians, practitioners and facilities have a signed contract with WHC in order to submit a claim?	A: Yes, yes, and yes! We recently had a client who had a biopsy performed by a WHC provider; however, the anesthesiologist was not a WHC provider. The patient has been turned over to collections by the anesthesiologist group. Services could have been paid by WHC if the case manager and the surgical office had ensured that all involved with care were WHC providers.
Q: What is the time frame for re-screen visits? WHC provides early detection through annual CBE, mammogram, and pap tests. "Re-screening" is the term used to identify clients returning for annual tests.	A: A visit qualifies as a re-screen if it occurs 12 to 18 months from the last screening procedure. Please align all of the screening services so they occur simultaneously or no more than 60 days apart. Funds allow only one office visit for CBE and pap. Clients who have had CBE, mammogram, and pap at different times need to have these services coordinated when re-screened.)

Billing Reminder

UGP Claim denials

All claims are to be submitted to UGP within 90 days from the date of service, but what should you do when a claim is denied on a current WHC client for a reimbursable service? Here is how to proceed:

- Do not resubmit the claim. A system correction is needed to reprocess and pay.
- You have 60 days to refute the denial from the date of the denial letter. E-mail Harold Johansen at the state office **ASAP**. (Johanseh@idhw.state.id.us) or call 208.334.5572.
- Give the client name and reason given for denial.
- If more than 60 days elapse, it will be necessary to document reason for delay in writing to:

  Women's Health Check
  Attn: Harold Johansen
  P. O. Box 83720
  Boise, ID 83720-0036

- The sooner the WHC state office is contacted, the easier to correct and process your payment.

2005 Reimbursement Rates are attached. Please discard old rate sheets after billing for 2004 services has been completed by your office.

Eligibility Reminder

Client Under 50 - When enrolled for **breast cancer risk or suspicion**- is eligible for cervical cancer screening if they are age 30 or above and are at risk or suspicion for cervical cancer.

Client Under 50 - When enrolled for **cervical cancer risk or suspicion**- is eligible breast cancer screening if age 50 or at risk or suspicion for breast cancer.
(Refer to Enrollment Approval for Women Under Age 50 Form.)

Program Provider Updates

Coming soon! The Women's Health Check Provider manual will be on-line this summer. The Women's Health Check **E-Manual** will be easy and convenient to use. Just watch the Idaho Department of Health and Welfare website (www.healthandwelfare.idaho.gov click on Women's Health Check) for more information and how to link-up.

Idaho Breast & Cervical Cancer ALLIANCE

Register on-line now!

www.themeetingnetworkinc.com/IBCCA2005.html

May 12-13, 2005
Idaho Breast and Cervical Cancer Alliance - Annual Conference
Sun Valley Lodge, Sun Valley, Idaho
Partnerships & Patient Focused Care

$125 Registration – 2 days (see website for details)
Lodging: $95/night, Sun Valley Lodge

Registration Details online: www.themeetingnetworkinc.com/IBCCA2005.html

Featuring national and local experts in the field of breast and cervical cancer on topics such as prevention, screening, diagnostics, cultural competency skills, case management, legal issues, genetics, and art and healing. **Continuing Education Credits are pending for nurses, Radiation Technologists, Social Workers, CHES**.

Hosted by Idaho Breast & Cervical Cancer Alliance and Women's Health Check. Sponsors include: St. Luke's Mountain States Tumor Institute, Breast Care Services, Saint Alphonsus Breast Care Center, the Idaho Hospital Association, and others.

Program Provider Updates

Q & A	
Q: What do I need to know about Women's Health Check financial eligibility guidelines?	**A:** The income limit is 200% of federal poverty level. This is determined yearly and published in the Federal Register the end of February. WHC updates its guidelines and sends to contractors at that time. (See attached.)
Q: What is counted as income?	**A:** Count total money coming in to the members of the household, earned and unearned. This means gross wages including self employment, as well as other cash benefits such as unemployment benefits, social security, disability and child support. Assets such as house, car, etc are not counted.
Q: What if the wages or income fluctuates?	**A:** Use the best and most reasonable monthly or yearly estimate.

The U. S. Department of Health and Human Services has released the 2005 Poverty Guidelines. If you would like further information regarding these Guidelines, please visit their website at http://aspe.hhs.gov/poverty/index.shtml .

Women's Health Check
2005 Income Eligibility Guidelines

Size of Family Unit	Annual Income	Monthly Income
1	$19,140	$1,595
2	$25,660	$2,138
3	$32,180	$2,682
4	$38,700	$3,225
5	$45,220	$3,768
6	$51,740	$4,312
7	$58,260	$4,855
8	$64,780	$5,398
For each additional person add:	$6,520	$543

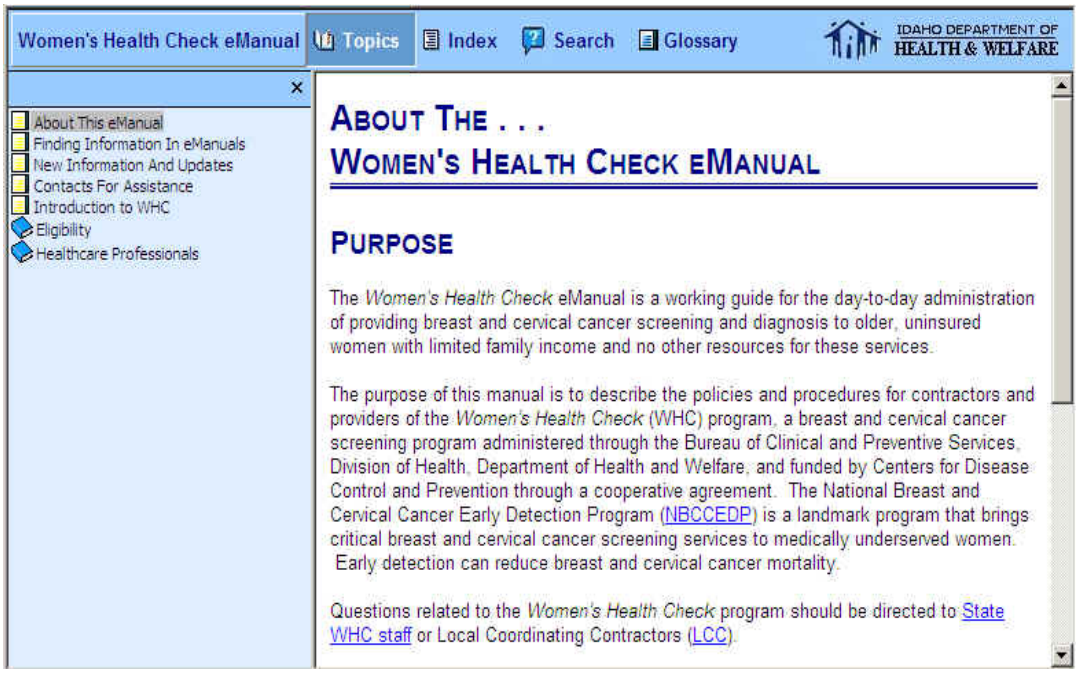
SOURCE: *Federal Register*, Vol. 70, No. 33, February 18, 2005, pp. 8373-8375.

WHC Program Provider Updates

July 1, 2005

Progress continues on the Women's Health Check E-Manual!

Sometime later this summer or early fall, the Women's Health Check Provider manual will be available via the Internet. This will allow for immediate access and quick searches. Here is a sample of what the E-Manual will look like:



The manual will also be available on a compact disk. For more information, contact Emily Geary at 208-334-5505 or gearye@idhw.state.id.us.

Idaho Breast and Cervical Cancer Alliance (IBCCA)

The IBCCA held the second annual statewide professional development conference in Sun Valley, May 12-13. Nearly 140 physicians, nurse practitioners, physician assistants, nurses, office managers, and public health staff attended sessions relating to cultural competency, breast and cervical cancer updates, body mechanics for mammographers, case management model, HPV epidemiology, Idaho cancer statistics, best practices for clinical visits, cancer clinical trials, and reading pathology reports. Up to 16 CE credits were available.

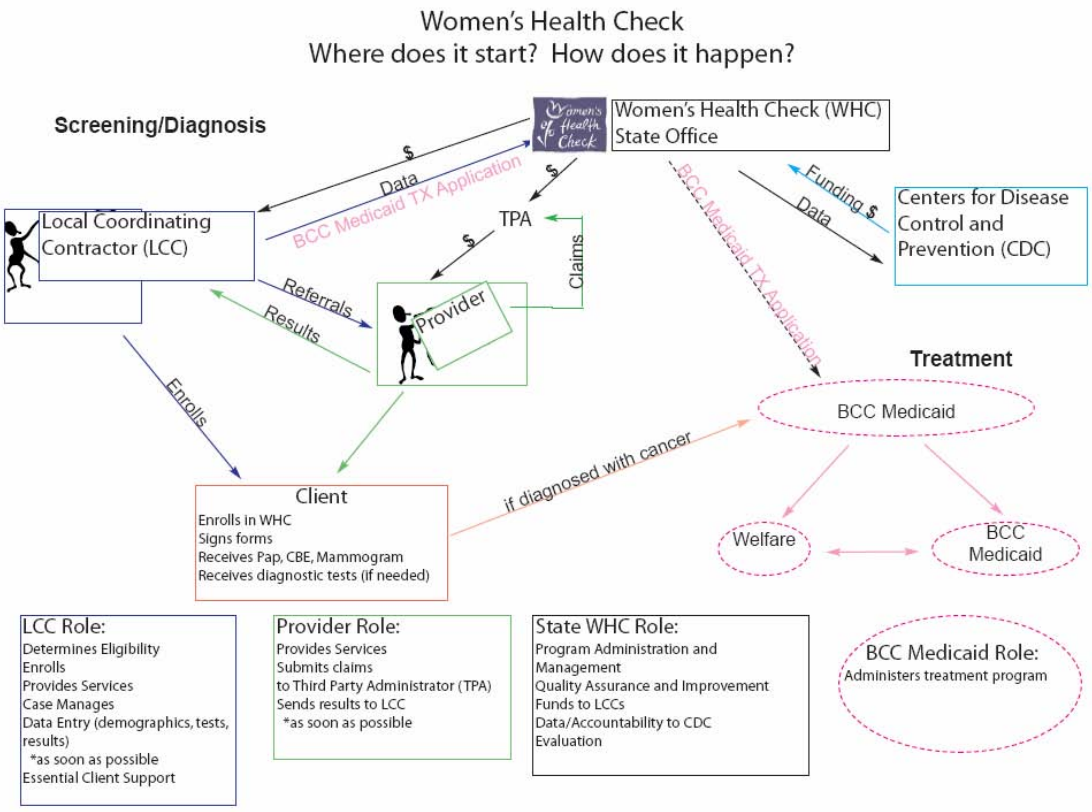
The IBCCA leadership hopes to hold next year's conference in Eastern Idaho, if hospitals and clinics in that region are willing to help sponsor and plan the event. If you are interested in making the conference a reality in Eastern Idaho, spring 2006, please contact Minnie Inzer Muniz, Women's Health Check Program Manager at (208) 332-7311, or email inzerm@idhw.state.id.us for more information. Co-chairs of the IBCCA are Norma Tulloch, Saint Alphonsus Hospital Breast Care Center Coordinator and Stacey Carson, Executive Director, Cancer Data Registry of Idaho, Idaho Hospital Association.

WHC Program Provider Updates

July 1, 2005

Almost everyday, WHC state office staff answers questions about how Women's Health Check operates. *Women's Health Check* client services are provided through a network of Local Coordinating Contractors (LCC) and over 300 health care providers who have signed a Memorandum of Agreement (MOA) with the state. Each LCC contracts with the State of Idaho, *Women's Health Check* program to recruit and enlist local providers, recruit and enroll clients, obtain and record data, and to provide timely and adequate case management. Providers are responsible for referred client services, and submitting results to the appropriate LCC as soon as available.

Presented below is an overview of Women's Health Check. Questions or comments can be sent to the WHC State office, 334-5805 or doeringt@idhw.state.id.us.



WHC Program Provider Updates

November 1, 2005

Kudos and **thanks** to you, we couldn't have done it without you!

Many Idaho women are receiving excellent health care thanks to you, the Women's Health Check participating providers.

The following report by the Centers for Disease Control and Prevention (CDC) shows Idaho's Women's Health Check program met or exceeded all performance indicators which measure if a program is serving the intended population and if the quality of those services meet guidelines.

Performance Indicator	CDC Standard	Idaho Results	Met Standard?	National Results
Pap tests for women who have not been screened in 5 years	>20%	38%	YES	20.8%
Screening mammograms for women over age 50	>75%	83.2%	YES	71.3%
Abnormal Cervical screening results with complete follow-up	>90%	93.8%	YES	87.7%
Abnormal Cervical results, diagnosed >60 days	<25%	19.0%	YES	36.3%
Cervical cancer treatment started for HSIL, CIN II, CIN III, CIS, Invasive	>90%	97.8%	YES	90.9%
HSIL, CIN II, CIN III, CIS treatment > 90 days	<20%	0%	YES	9.0%
Invasive Cervical cancer treatment >60 days	<20%	0%	YES	11.3%
Abnormal breast screening results with complete follow-up recorded	>90%	97.5%	YES	88.9%
Abnormal breast screening to diagnosis >60 days	<25%	9.6%	YES	18.7%
Breast cancer treatment started	>90%	100%	YES	89.5%
Breast cancer – time from diagnosis to treatment >60 days	<20%	0%	YES	7.1%

What do WHC clients have to say? In a recent telephone survey, women who received screening and diagnostic services through Women's Health Check providers made the following comments:

- "I didn't realize I would receive such good care."
- "I thought it was a very good, positive experience in having a mammogram."
- "WHC is a great program for women who don't have insurance. They are good on follow-up calls. Overall, it's a great program."

Can we rest on our laurels? Absolutely not! Here are some alarming statistics:

- Idaho ranks last in the nation for the rate of women over age 40 who have had a mammogram within the past two years.
- Idaho ranks second lowest in the nation for women who have regular Pap tests.

WHC Program Provider Updates

November 1, 2005

Let's continue to work together to improve these rates and to decrease the number of women who have undetected breast or cervical cancers.

New resources:

- **WHC Real Time Data Base** – Our data system is now live and in real time. By the end of this year, all of the Local Coordinating Contractors (LCC) will be converted to a web based system.
  - Please forward all results and findings to the LCCs ASAP.
  - This will help to maintain the excellent care our patients are receiving and keep us in good standing on our national performance indicators and future funding.

- **CD ROM Training Tool** – A great way to learn about Women's Health Check
  - Use it for new staff.
  - Use it to access specific information about the program.
  - Watch all or part (5 to 6 minutes per section).
  - Copies are available from your LCC.

- **Women's Health Check E- Manual for Providers and LCCs -** is available on-line at www.healthandwelfare.idaho.gov. Scroll down and click on Women's Health Check on the right hand side. On the Women's Health Check page, the manual is located under resources towards the bottom of the page. To read the manual, you need Adobe Acrobat Reader.

  Some tips for working in the manual:
  - The table of contents is located under Bookmarks. Click on the plus sign to see all topics for that section.
  - Clicking on a topic will take you to that section of the manual.
  - The manual is interactive. Links (text highlighted in blue) take you to related information such as covered services, reimbursement rates, standards of care, and a myriad of other resources for professional and patient use by just a click.
  - Find and print the most current version of our forms.

******To receive a copy of the Women's Health Check e-manual for providers and LCCs, FAX this form to 208-334-0657.**

- ☐ **CD**
- ☐ **Paper copy**

Send to:

Name: _____

Address: _____

_____

_____

Save the Date!

Join the Idaho Breast and Cervical Cancer Alliance (IBCCA)

April 27 – 28, 2005

Shilo Inn, Idaho Falls, Idaho

for the annual Partnerships & Patient Focused Care conference.

More details at: **www.idcancer.org/ibcca**

Women's Health Check

A breast and cervical cancer screening program

Program Update – Feb. 2006

Women's Health Check served almost 3600 women in 2005.*

- *1428 women received a mammogram through WHC for the first time.*
- *1733 women returned to WHC for a mammogram.*
- *1856 women received pap tests to screen for cervical cancer.*
- *80 women diagnosed with cancer through WHC.*

*Unduplicated count for state fiscal year 2005.

Women can receive both breast and cervical cancer screening services.

Women's Health Check, Screening for Women in Need. Every year, Women's Health Check (WHC) provides breast and cervical cancer screening to eligible women. Funding for these services comes from the Centers for Disease Control and Prevention (CDC). Congress mandates that at least 75% of screening services go to low income, uninsured, underserved women ages 50 – 64, who are the priority population. A limited number of eligible women under age 50 can be referred to WHC for diagnostic tests, as funding allows.

These distinctions are especially important as WHC anticipates waiting lists for client enrollment and services, especially for under age 50 referrals. Women's Health Check received funding to screen approximately 3500 women for this fiscal year and will reach that number sometime this spring. The WHC state office monitors clients served and claims submitted very closely to make sure that the intent of Congress is met and that the budget is not over spent.

By working closely with your local WHC contact (LCC), any interruption to services should be minimal. More information about how to enroll and serve women who qualify for WHC screening services will be released in a special edition of the WHC Program Update. While this seems daunting, it is actually good news for WHC because it demonstrates WHC uses the funding it receives and makes sure it is going to the women who can most benefit from cancer screening services.

The WHC Program has received commendation from the CDC for timely diagnosis and initiation of treatment of women enrolled in WHC. This seamless service can only happen when:

- The LCC (local WHC contact) is notified of the diagnosis of cancer or pre-cancer by the provider.
- The LCC completes presumptive eligibility forms and submits to Medicaid for treatment coverage.
- The BCC Medicaid Program approves the patient and LCCs and provider(s) are notified.

WHC does not cover treatment. Treatment through BCC Medicaid is not automatic. The Third Party Administrator (UGP) cannot reimburse for treatment.

Your LCC and the patient rely on you, the provider, to communicate any diagnosis that will need treatment ASAP.

WHC Real Time Database

As of January, 2006, all of WHC is real! All data collected by the program is now entered into the WHC Real Time Database. This means no more time lags between state and local data entry which will result in women receiving the services they need promptly especially if there has been an abnormal finding. And claims will be handled

more quickly, too.

You can help by making sure results are quickly provided to your LCC who will enter the data directly into the real time system. Previously, data was entered locally, sent monthly to the state and then re-entered. No double entry now.

The data gathered in the WHC program is used for three primary purposes. First, making sure women who have abnormal findings are followed through to a diagnosis. Secondly for strategic planning – the allocation of program resources to meet the needs of Idaho women in the coming year. And finally for quality assurance – the data is forwarded to the Centers for Disease Control and Prevention to help evaluate WHC's effectiveness.

Coming soon to a computer screen near you! WHC is proud to announce the release of a CD containing information about WHC. This training CD offers a visual and audio overview of the day-to-day administration of providing breast and cervical cancer screening and diagnosis to older, uninsured women with limited family income and no other resources for these services.

Local WHC contacts and health care's professional staff will find this an easy way to share what WHC does, determine who is eligible, and why case management is so important among other topics. No segment is over 5 minutes long and in total, the CD takes approximately 20 minutes to view. Copies of the CD are available from your local WHC contact.

Q & A

Question: A documented immigrant has been diagnosed and needs treatment. Will she qualify for BCC Medicaid?

Answer: Possibly. While WHC has no enrollment restrictions related to citizenship, Idaho Medicaid does. The best way to handle this is to have the LCC submit a copy of both sides of the alien ID card to the WHC state office to determine if she meets the criteria. Qualifying for Idaho BCC Medicaid will not jeopardize application for citizenship.

www.healthandwelfare.idaho.gov
scroll on the left hand side to Women's Health Check

Contact Information

NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM[1]

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a nationwide, comprehensive public health program that helps uninsured and underserved women gain access to screening services for the early detection of breast and cervical cancer.

Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the United States. Screening for and early detection of breast and cervical cancer reduces death rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of certain racial and ethnic minorities and among under- or uninsured women, which creates a wide gap in health outcomes between such women and other women in the United States. To address this health disparity, Congress authorized the NBCCEDP in 1990, giving CDC the ability to implement a national strategic effort to increase access to mammography and Pap test screenings for women in need.

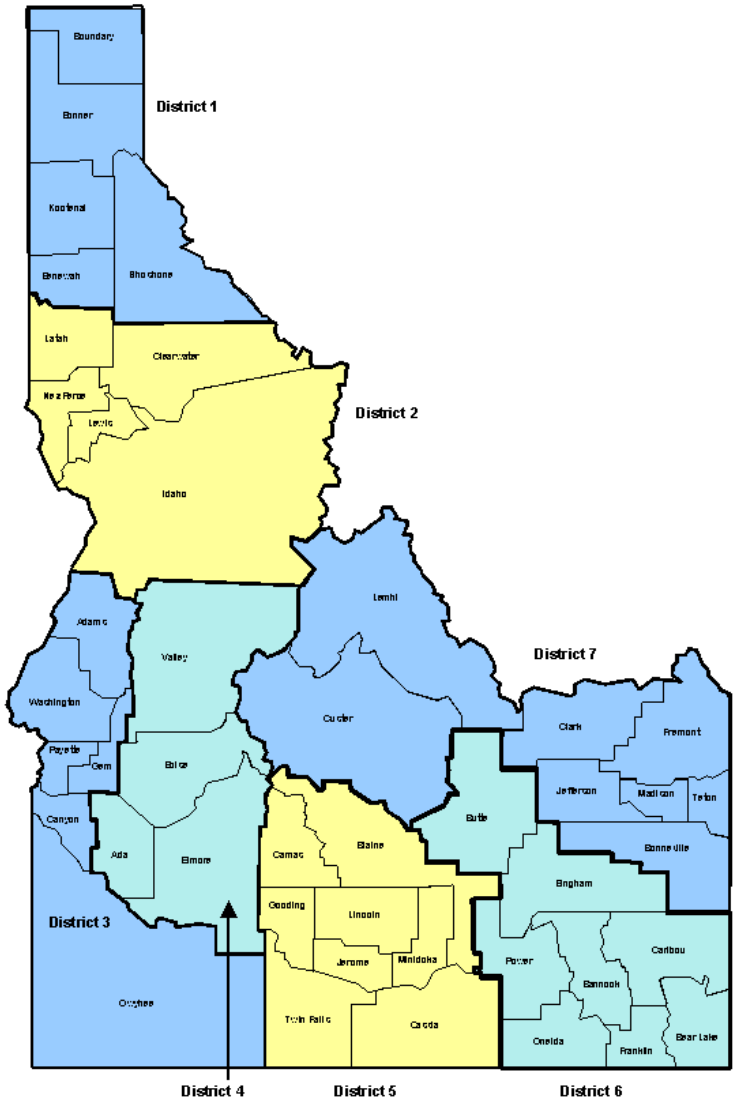
The NBCCEDP is implemented through cooperative agreements with state and territorial health departments, tribes, and tribal organizations (grantees). Sixty percent of federal funds received by a grantee must be expended on direct services for women. The other 40% of federal funds can be used to support program management, public and provider education, quality assurance, and surveillance and evaluation activities. The NBCCEDP is intended to be the payer of last resort for screening services; therefore, grant monies cannot be used to pay for services if other coverage is available through any state fund, private health insurance, or other government health benefits program such as Medicaid or Medicare. Grantees are also required to maintain and document matching effort, $1 for every $3 of federal funds. Grantees contract with a broad range of provider agencies to deliver screening and other services, and each grantee has developed its own delivery system based on available resources.

The NBCCEDP is directed to low-income, uninsured women aged 18–64 from priority populations. The program provides clinical breast examinations, mammograms, and Pap tests for eligible women who participate in the program as well as diagnostic testing for women whose screening outcome is abnormal. Although treatment services are not directly paid for by the NBCCEDP, programs have always been required to identify resources for the treatment of breast and cervical cancer found through the program. To assist programs in identifying these resources, in 2000 Congress gave the states the option to provide medical assistance for treatment through Medicaid (PL 106-354). In addition to screening and diagnostic services, the legislation authorizing the NBCCEDP (PL 101-354) provided for public and professional education, quality assurance, and surveillance and evaluation systems to monitor program activities. Each grantee reports to CDC a subset of program data known as the minimum data elements (MDEs). The MDEs are a set of standardized data elements considered to be minimally necessary for grantees and CDC to monitor client demographics and clinical outcomes of women screened with NBCCEDP funds. The MDEs also are used to establish NBCCEDP policies and practices, assess the national program's screening outcomes, and respond to the information needs of CDC stakeholders and partners.

To access information on a specific state, territory or American Indian/Alaska Native organization: http://apps.nccd.cdc.gov/cancercontacts/nbccedp/contacts.asp

[1]Centers for Disease Control and Prevention. *The National Breast and Cervical Cancer Early Detection Program 1991–2002 National Report*. Atlanta (GA): Department of Health and Human Services; 2005.

WOMEN'S HEALTH CHECK CONTRACTORS



WOMEN'S HEALTH CHECK
LOCAL COORDINATING CONTRACTORS
IDAHO HEALTH DISTRICTS

	District	Address	Phone	Fax	Coordinator
1	Panhandle District Health	8500 N. Atlas Road Hayden, ID 83835	415-5100	451-5101	Gail Turley
2	North Central District Health	215 10th St. Lewiston, 83501	799-3100	799-0349	Maggi Alsager
3	Southwest District Health	920 Main St. Caldwell, 83605	455-5300-C 549-2370-W 365-6371-E	455-5386-C 549-2371 -W	Debbie Dobbs
5	South Central Health District	1020 Washington St. N. Twin Falls, 83301-3156	737-5935	734-9502	Sharlynn Van Tassell
6	Southeast District Health	1901 Alvin Ricken Drive Pocatello, 83201	239-5232	478-9297	Dana Bezdeka
7	District Seven Health Dept	254 E Street Idaho Falls, 83402	522-0310 x129	525-7063	Pat Fletcher

OTHER LOCAL COORDINATING CONTRACTORS

Facility	Address	Phone	Fax	Coordinator
Terry Reilly Health Services	223 16th Avenue North Nampa, 83653	466-7869	466-5359	Roxanne Ohlund (318-1260)
Family Practice Residency of Idaho	777 North Raymond Boise, ID 83704	367-6638	947-0913	Sharene Brown
St. Alphonsus Breast Care Center	6200 W. Emerald Boise, Idaho 83704	367-7761	367-3390	Julie Orgill

State Staff

Breast and Cervical Cancer Early Detection

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Administration:	Terresa Doering, Administrative Assistant 208-334-5805 doeringt@idhw.state.id.us
Clinical Quality Assurance and Improvement:	Jeanie Scepka, Senior Nurse 208-334-5971 scepkaj@idhw.state.id.us
Education, Outreach and Partnerships:	Emily Geary, Community Resource Coordinator 208-334-5505 gearye@idhw.state.id.us
	Patty Maddox, Administrative Assistant 1 - Part Time 208-334-5589 maddoxp@idhw.state.id.us
Evaluation, Surveillance and Data Management:	Harold Johansen, Data Manager 208-334-5572 johanseh@idhw.state.id.us
	Lisa Slaughter Stones, Tech Specialist 2 - Part Time 208-334-6956 slaughtl@idhw.state.id.us

Women's Health Check Fax:
208-334-0657